

Diplomate, American Board of Orthodontics

ID. _____

Date of Exam: ____/____/____

Date of Birth: ____/____/____

Patient's Name: (Last) _____ (First) _____ M.I. _____ Age: _____ Sex: M / F

Address _____ City _____ Zip _____ Home Ph: _____

Patient's Cell Ph: _____ Email Contact: _____ Other Contact: _____

Dentist's Name: _____ Address: _____ Ph: _____ Referred by: _____

PART A - MINOR PATIENTS (UNDER AGE 18)

School: _____ Grade: _____ Hobbies _____ Nickname _____

MOTHER SS# ____/____/____ DOB ____/____/____ Marital Status: M / D / S

Address _____ City _____ Zip _____ Home Ph: _____

Employer: _____ Position: _____ Wk Ph: _____ Cell Ph: _____

FATHER SS# ____/____/____ DOB ____/____/____ Marital Status: M / D / S

Address _____ City _____ Zip _____ Home Ph: _____

Employer: _____ Position: _____ Wk Ph: _____ Cell Ph: _____

Names and ages of other children in family: _____

PART B - ADULT PATIENTS

Employer: _____ Position: _____ Wk Ph: _____ SS # ____/____/____

Spouse/Partner: _____ SS # ____/____/____ DOB ____/____/____ Cell Ph: _____

Employer: _____ Position: _____ Wk Ph: _____ Other: _____

PART C - FINANCIAL INFORMATION

RESPONSIBLE PARTY: _____ Contact Nos.: _____

Address: _____ SS # ____/____/____ DOB: ____/____/____

RELATIVE NOT LIVING WITH YOU: _____ Relationship: _____

Address: _____ Contact Nos.: _____

PART D - MEDICAL HISTORY

Is patient in good health? Yes No Patient's Physician _____ Ph: _____

Is patient under care of physician No Yes If yes, since when and why? _____

Does patient have any history of a major illness? (Check those that apply)

Rheumatic Fever Anemia Hepatitis Diabetes Heart Disease Bone Disorders

Prolonged Bleeding Epilepsy AIDS Pneumonia Nervous Disorders Liver Disorders

Fainting & Dizziness Cancer Asthma Kidney Disease Endocrine Problems _____

Is there any disease, condition, or problem not listed above or anything else we should know about your health that we have not covered in this form? _____

Does patient have tendency to: Colds Sore throats Ear infections

Have tonsils and adenoids been removed? No Yes If yes, at what age? _____

List any drugs or medications now being taken. Give Reasons. _____

List any allergies or drug sensitivities: _____

*(Minors Only) Height _____ Weight _____ Has the patient reached puberty? Yes No

Girls - Has started menstruation? Yes No; Boys - Has voiced changed? Yes No

PART E - DENTAL HISTORY

Approximate date of last dental exam: ____/____/____ Were x-rays taken? Yes _____ No

Has there been any injuries to the face, mouth or teeth? Yes _____ No

Has the patient ever sucked a thumb or fingers? Yes If so, until what age? _____ No

Does the patient have any speech problems? Yes _____ No

Is the patient a mouth breather? Yes If so, while awake? while asleep? _____ No

Has patient been informed of any missing or extra permanent teeth? Yes If yes, please describe _____ No

Has an orthodontist been consulted previously? Yes _____ No

Has either parent had orthodontic treatment? Yes If so, any teeth extracted? _____ No

List any musical instruments played _____

Reason for consultation: _____

PART F - INSURANCE INFORMATION

Primary Subscriber: _____ ID # _____ DOB _____

Insurance Carrier Name: _____ Group # _____ Coverage: _____

Address _____ Ph No. _____

Secondary Subscriber: _____ ID # _____ DOB _____

Insurance Carrier Name: _____ Group # _____ Coverage: _____

Address _____ Ph No. _____

Additional Subscriber: _____ ID # _____ DOB _____

Insurance Carrier Name: _____ Group # _____ Coverage: _____

Address _____ Ph No. _____

PART G - FLEX PLAN/MEDICAL SAVINGS INFORMATION

Do you have a flexible spending account? No Yes, If so, flex plan year start date: Mo. ____ Yr. ____ Amount? _____

I certify that the above information is complete and accurate.



x _____

Patient's Signature (or parent if patient is a minor)