

Please fill out this form and bring it with you to your first appointment. We look forward to meeting you.

**Part I – Patient Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State & Zip: \_\_\_\_\_  
Email Address: \_\_\_\_\_ Would you like to receive notices by e-mail: Y / N  
Home Phone: \_\_\_\_\_ Nickname: \_\_\_\_\_  
Sex: Male ( ) Female ( ) Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
School: \_\_\_\_\_ Grade: \_\_\_\_\_ Number of Siblings: \_\_\_\_\_ Ages ( ) ( ) ( ) ( )  
Musical Instruments played: \_\_\_\_\_ Favorite Sports or Hobbies \_\_\_\_\_

**Part II –Guardian Information:**

**(Primary)**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State & Zip: \_\_\_\_\_  
Years at current address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SS# \_\_\_\_\_  
Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_  
Work Phone Number: \_\_\_\_\_ Occupation: \_\_\_\_\_ Years Employed: \_\_\_\_\_  
Dental Insurance Carrier: \_\_\_\_\_ Subscriber Number: \_\_\_\_\_

**(Secondary)**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State & Zip: \_\_\_\_\_  
Years at current address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SS# \_\_\_\_\_  
Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_  
Work Phone Number: \_\_\_\_\_ Occupation: \_\_\_\_\_ Years Employed: \_\_\_\_\_  
Dental Insurance Carrier: \_\_\_\_\_ Subscriber Number: \_\_\_\_\_

Who is Financially Responsible: \_\_\_\_\_  
Whom may we thank for this referral: \_\_\_\_\_  
Emergency contact person: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Part III – Patient Dental History:**

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_ Address: \_\_\_\_\_ Last Exam: \_\_\_\_\_  
What is your (or your child's) chief complaint: \_\_\_\_\_  
Does anyone else in the family have any similar conditions? (crowded, protruded teeth or jaws, poor bite): \_\_\_\_\_  
Any family member received orthodontic treatment? \_\_\_\_\_ Who? \_\_\_\_\_  
Tonsils and adenoids present? \_\_\_\_\_ Any tooth clenching or grinding at night? \_\_\_\_\_

Any thumb or finger habits? \_\_\_\_\_ To what age? \_\_\_\_\_  
 Other habits? \_\_\_\_\_ Smoking/ tobacco habits? \_\_\_\_\_ Difficulty chewing food? \_\_\_\_\_  
 Any difficulty in breathing through the nose, awake or asleep? \_\_\_\_\_  
 Any clicking or pain in jaw? \_\_\_\_\_ Teeth sensitivity to cold, heat, sweets or pressure? \_\_\_\_\_  
 Does your child brush and clean teeth properly? \_\_\_\_\_ Floss teeth? \_\_\_\_\_  
 Is your child in good health? \_\_\_\_\_ Patients weight: \_\_\_\_\_ Height: \_\_\_\_\_  
 Is your child currently under a physicians care? \_\_\_\_\_ If yes, please describe: \_\_\_\_\_  
 Is your child taking any medications? \_\_\_\_\_ If yes, please list: \_\_\_\_\_

**Part IV - Medical History:**

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Address: \_\_\_\_\_ Last Exam: \_\_\_\_\_

*For the following questions circle yes, no, or don't know/ understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.*

yes no dk/u	Allergies to Drugs	yes no dk/u	Sinus Problems
yes no dk/u	Allergies to Anesthetics	yes no dk/u	Rheumatic Fever
yes no dk/u	Hay Fever or Allergies in general	yes no dk/u	Neurological Problems
yes no dk/u	Any Heart Ailments	yes no dk/u	Thyroid Disorders
yes no dk/u	Heart Murmur	yes no dk/u	Eye Disorders
yes no dk/u	High Blood Pressure	yes no dk/u	Tonsillitis
yes no dk/u	Anemia or Blood Problems	yes no dk/u	Tuberculosis
yes no dk/u	Arthritis	yes no dk/u	Ulcer or Colitis
yes no dk/u	Radiation Treatments	yes no dk/u	Venereal Disease
yes no dk/u	Diabetes	yes no dk/u	Headaches
yes no dk/u	Asthma	yes no dk/u	Jaw "Locking"
yes no dk/u	Stroke	yes no dk/u	Ear-aches, ringing, ear-stuffiness
yes no dk/u	Kidney Problems	yes no dk/u	Psychiatric/ Emotional Problems
yes no dk/u	HIV Positive or AIDS Virus	yes no dk/u	Excessive Bleeding from cut/extraction
yes no dk/u	Respiratory Disease	yes no dk/u	History of Fainting
yes no dk/u	Liver Problems or Hepatitis	yes no dk/u	Pregnancy, If so what month _____
yes no dk/u	Malignancies	yes no dk/u	Stomach or Intestinal Disease
yes no dk/u	Tumors or Growths	yes no dk/u	Any Surgeries, If so what _____

**Part V – Patient Consent:**

*Dr. New has my permission to obtain diagnostic materials she deems necessary for orthodontic evaluation. I also authorize her to provide other health care providers with information regarding my child's orthodontic care if considered appropriate. I also understand it is my responsibility to keep Dr. New's office informed of any change in medical or dental health status and that when appropriate, a credit bureau report may be obtained.*

Parent/ Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_