

Patient Information

Date _____

 Patient's Name _____ / _____ Male Female
Last First Middle Nickname

 Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Age _____ Social Security No. _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

 Name _____ Mr. Mrs. Ms. Dr.
Last First Middle

 Residence _____ Home phone _____
Street City State Zip

 Mailing Address _____ Work phone _____
Street City State Zip

How long at this address? _____ Drivers License _____ Cell Phone _____

Previous Address (if less than 3 years) _____

Social Security No. _____ E-mail _____ Relationship to Patient _____

Employer _____ Occupation _____ No. years employed _____

Spouse's Name _____ Relationship to Patient _____

Social Security No. _____ E-mail _____ Cell Phone _____

Employer _____ Occupation _____ No. years employed _____

Dental Insurance Information

Insured's Name _____ Insured's Soc Sec No. _____ Date of Birth _____

Insurance Co. _____ Group No. _____ Phone _____

Insurance Co. Address _____

 Do you have dual coverage? Yes No If yes, please complete:

Insured's Name _____ Insured's Soc Sec No. _____ Date of Birth _____

Insurance Co. _____ Group No. _____ Phone _____

Insurance Co. Address _____

Emergency Contact Information

Name of nearest relative not living with you _____ Relationship _____

 Complete address _____
Street City State Zip

Home phone _____ Other phone _____

I understand that, where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

Updates (date and initial) _____

Medical History

Physician _____ Phone _____ Date of Last Visit _____

Please check Yes or No. (If Yes, please fill in details)

Yes No Are you taking any medications? _____

Yes No Are you allergic to any medications? _____

Yes No Do you have a history of a major illness? _____

Yes No Have you had any major operations? _____

Yes No Have you ever been involved in a serious accident? _____

For Female Patients Only:

Yes No Are you pregnant? _____

Yes No Has menstruation started? _____

Check any of the medical conditions below that you have had or currently have.

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Abnormal bleeding/Hemophilia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis/Liver problems | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Herpes | <input type="checkbox"/> Prolonged Bleeding |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Radiation/Chemotherapy |
| <input type="checkbox"/> Asthma or Hay Fever | <input type="checkbox"/> Gastrointestinal Disorders | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bone Disorders | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumor or Cancer |

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

Dental History

Dentist _____ Phone _____ Date of Last Cleaning _____

What concerns you most about your teeth? _____

Yes No Are you presently in any dental pain? _____

Yes No Have you ever experienced any unfavorable reaction to dentistry? _____

Yes No Have you ever lost or chipped any teeth? _____

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

Yes No Is any part of your mouth sensitive to temperature or pressure? _____

Yes No Do your gums bleed when you brush? _____

Yes No Do you have any type of thumb or tongue habit? _____

Yes No Are you a mouth breather? _____

Yes No Have you ever seen an orthodontist? If yes, who and when? _____

Yes No What is your attitude toward receiving orthodontic treatment? _____

Yes No Has anyone in your family received orthodontic treatment? _____
How did they feel about the result? _____

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____

Yes No Are you aware of your jaw clicking or popping? _____

Yes No Are you aware of clenching your teeth during the day? _____

Yes No Have you ever been told that you grind your teeth? _____

Yes No Do you have "tension" headaches? _____

Yes No Have you ever experienced chronic ringing in your ears? _____

Yes No If the patient is under age 16, What is the height of parents? Mom _____ Dad _____

Yes No Are you aware that some appointments will be during school/work hours? _____
Please list some hobbies or interests _____

Benefits. The benefits of orthodontics are aesthetics, health and function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I have truthfully answered all of the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Apple Orthodontix to perform a complete orthodontic evaluation.

Privacy Policies. I understand that this office is HIPAA compliant. I hereby acknowledge that the privacy statement is available for me to read and obtain a copy at my request.

Signature _____ Date _____