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Member American Association of Orthodontists

PATIENT INFORMATION

Date _____ Date of Birth _____ Age _____ E-Mail Address _____

Patient's Name _____

Home Address _____
Street City State/Zip

Home Phone _____ Work Phone _____ Cell Phone _____

If Patient is a minor:

Father's Information _____
Name Home Phone Work Phone Cell Phone

_____
Home Address Occupation

Mother's Information _____
Name Home Phone Work Phone Cell Phone

_____
Home Address Occupation

Patient's Physician _____ Patient's Dentist _____

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

INSURANCE INFORMATION

Subscriber's Name _____ Birthdate _____ SS# _____

Insurance Company _____
Name Address Phone Number

Employer _____ Group Number _____

Person Responsible For This Account

I authorize this office to release any information necessary to expedite insurance claims. I understand that I am financially responsible for all charges, regardless of insurance coverage.

Parent or Guardian Signature _____ Date _____

MEDICAL HISTORY

Date of patient's last physical examination _____

Does patient have or ever had:

Anemia ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No

Hepatitis ☐ Yes ☐ No

Allergies:

Penicillin ☐ Yes ☐ No

Local Anesthetic ☐ Yes ☐ No

Other _____

Abnormal Heart Condition ☐ Yes ☐ No

Rheumatic Fever ☐ Yes ☐ No

Abnormal Bleeding from a cut ☐ Yes ☐ No

Heart Murmur ☐ Yes ☐ No

Is the Patient under medical care now? ☐ Yes ☐ No

If so, for what? _____

Is the Patient taking any medications now? ☐ Yes ☐ No

Please list _____

Does Patient have any other medical conditions? ☐ Yes ☐ No

Please list _____

_____

_____

_____

_____

Information given by (signature) _____ Date _____