A B C

Patient Information

Date _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Social Security # _____

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 _____ _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ E-Mail Address _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Insured's Employer _____

Do you have dual coverage? Yes ☐ No ☐ If yes:

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Insured's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

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

Signature (Parent's signature if minor) _____

Updates (date & initial) _____

Medical History

IS PATIENT IN GOOD HEALTH? ☐ YES ☐ NO

DOES PATIENT HAVE ANY HISTORY OF MAJOR ILLNESS? ☐ YES ☐ NO

HAS THE PATIENT EVER BEEN UNDER THE CARE OF A PHYSICIAN FOR MAJOR ILLNESS? ☐ YES ☐ NO

PLEASE LIST _____

DOES PATIENT HAVE TENDENCY TO ☐ COLDS ☐ SORE THROATS ☐ EAR INFECTIONS

HAVE TONSILS AND ADENOIDS BEEN REMOVED? ☐ YES ☐ NO WHAT AGE? _____

DOES THE PATIENT USE ANY TOBACCO PRODUCTS? _____ PLEASE SPECIFY _____

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN (GIVE REASON)

_____

LIST ANY ALLERGIES OR DRUG SENSITIVITY _____

_____

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

- ☐ DIABETES
- ☐ PNEUMONIA
- ☐ HEART TROUBLE
- ☐ RHEUMATIC FEVER
- ☐ BONE DISORDERS
- ☐ TUBERCULOSIS
- ☐ ANEMIA
- ☐ EPILEPSY
- ☐ ACQUIRED IMMUNE DEFICIENCY (AIDS)
- ☐ ASTHMA
- ☐ KIDNEY INVOLVEMENT
- ☐ ENDOCRINE PROBLEMS
- ☐ PROLONGED BLEEDING
- ☐ FAINTING OR DIZZINESS
- ☐ NERVOUS DISORDERS
- ☐ LIVER INVOLVEMENT
- ☐ HIGH/LOW BLOOD PRESSURE
- ☐ HEPATITIS

PATIENT'S PHYSICIAN(S) _____

_____

Dental History

HAS THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH? ☐ YES ☐ NO

DOES THE PATIENT HAVE ANY SPEECH PROBLEMS? ☐ YES ☐ NO

HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH? ☐ YES ☐ NO

HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY? ☐ YES ☐ NO

HAS EITHER PARENT HAD ORTHODONTIC TREATMENT? ☐ YES ☐ NO

HAS THE PATIENT EVER SUCKED A THUMB OR FINGERS? ☐ YES ☐ NO

UNTIL WHAT AGE? _____

IS THE PATIENT A MOUTH BREATHER? ☐ YES ☐ NO

WHILE AWAKE? _____ WHILE ASLEEP? _____

PATIENT'S GENERAL DENTIST _____ CITY _____ PHONE _____

LAST CLEANING _____

IS THERE ANY ADDITIONAL INFORMATION YOU WOULD LIKE US TO BE AWARE OF? _____

_____

SIBLINGS NAMES & AGES _____

_____

Disclosure

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____