(817) 488-1150
754 North Carroll Avenue
Southlake, Texas 76092

PATIENT INFORMATION

PATIENT'S NAME ____________________ NICKNAME ____________

ADDRESS ____________ CITY ____________ ZIP ________

PATIENT'S BIRTHDATE ____________ AGE ______ SEX ______ HOME PHONE ____________

OCCUPATION or SCHOOL ____________ WHO MAY WE THANK FOR REFERRING YOU? ____________

PATIENT'S DENTIST ____________ DATE OR LAST CLEANING ____________

MEMBER(S) OF FAMILY WHO HAS UNDERGONE ORTHODONTIC TREATMENT ________ WHERE? ________

NAME AND AGES OF CHILDREN or SIBLINGS ____________________

RESPONSIBLE PARTY INFORMATION

NAME ____________________ RELATIONSHIP TO PATIENT ________

ADDRESS ____________________ HOME PHONE ____________

CELL PHONE ____________________

SOCIAL SECURITY# ____________ EMAIL ADDRESS ____________

EMPLOYER ____________________ BIRTHDATE ____________

SPOUSE'S NAME ____________ RELATIONSHIP TO PATIENT ____________

SOCIAL SECURITY # ____________ BIRTHDATE ____________

CELL PHONE ____________ E-MAIL ADDRESS ____________

ORTHODONTIC INSURANCE INFORMATION

IS PATIENT COVERED BY INSURANCE FOR ORTHODONTIC TREATMENT? YES ________ NO ________

INSURER'S NAME ____________________ BIRTHDATE ____________

INSURANCE COMPANY ____________ ID # ____________

WHAT ARE YOUR ORTHODONTIC CONCERNS? ____________________

____

Please check if applicable

HEALTH HISTORY

- ❑ Adenoids removed
- ❑ AIDS
- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial heart valves
- ❑ Asthma
- ❑ Bleeding disorder
- ❑ Bone disorder
- ❑ Cancer treatment
- ❑ Cardiac pacemaker
- ❑ Congenital heart defect
- ❑ Chronic cough
- ❑ Diabetes
- ❑ Ear problems
- ❑ Endocrine problems
- ❑ Epilepsy
- ❑ Faintness/Dizziness
- ❑ Headaches (frequent)
- ❑ Heart murmur
- ❑ Heart trouble
- ❑ Hepatitis
- ❑ Herpes
- ❑ High blood pressure
- ❑ Jaundice
- ❑ Joint swelling
- ❑ Osteoporosis
- ❑ Rheumatic Fever
- ❑ Sinus trouble
- ❑ Stroke
- ❑ TMJ
- ❑ Tonsils removed
- ❑ Tuberculosis
- ❑ Venereal disease
- ❑ Any injuries to the face, mouth, teeth? (Circle)
- ❑ Thumb, finger, or lip sucking? (Circle)
- ❑ Mouth-breathing when asleep, awake? (Circle)
- ❑ Any missing or extra permanent teeth? (Circle)
- ❑ Any teeth removed by extraction?
- ❑ Is there a tongue-thrust problem?
- ❑ Any speech problems?
- ❑ Any pain or clicking when opening mouth?
- ❑ has an orthodonitist been consulted previously? Reason ____________
- ❑ Play any wind instruments

List any unusual medical history or situation of which you feel we should be informed ____________

List any allergies ____________

SIGNATURE

DATE