

Patient Full Name: _____

Nickname / Name I Prefer To Be Called:		Home Telephone:			
		Mobile Phone:			
Patient's Address:			How long at this address:		
Date of Birth:	Age:	Sex:	Employer Telephone:		
School/Employer:		Length of Employment:	Email Address:		
Social Security Number:		For Child Patients, Names and Ages of Brothers & Sisters:			

***** FOR PATIENTS UNDER 18 YEARS, PLEASE COMPLETE BOTH PARENTS' INFORMATION*****

Parent Full Name: <small>(If you are an adult patient, go to Section Two)</small>		Home Telephone:			
<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Step-Parent		Mobile Phone:			
Address:			How long at this address?		
Employer:		Employer Telephone:			
Length of Employment:	Email Address:		Marital Status:		
Social Security Number:		Date of Birth:			
Other Parent Full Name:		Home Telephone:			
<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Step-Parent		Mobile Phone:			
Address:			How long at this address?		
Employer:		Employer Telephone:			
Length of Employment:	Occupation / Position:		Marital Status:		
Social Security Number:		Date of Birth:			

DENTAL

*****SECTION TWO*****

Insurance Information PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST SO THAT WE MAY MAKE A COPY OF IT FOR OUR FILES

Name of Primary Orthodontic Insurance Co:		Insurance Co Telephone #:	
Name of Policy Holder (Employee):		Employee Relationship to Patient: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Step Parent <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other (specify):	
Policy Holder Date of Birth:	Policy Holder ID#:	Policy Holder Social Security #:	
Do you have secondary orthodontic insurance coverage? YES NO			

FOR ALL PATIENTS - PLEASE COMPLETE THE FOLLOWING

How Did You Hear About Us?	<input type="checkbox"/> Dentist <input type="checkbox"/> Patient <input type="checkbox"/> Relative <input type="checkbox"/> Phone Book <input type="checkbox"/> Other		
Whom May We Thank For Referring You To Us?	Reason For Today's Visit With Us:		
Present Dentist:	Date of Last Dental Cleaning:		

FOR ALL PATIENTS - PLEASE CHECK ALL THAT APPLY

Aids <input type="checkbox"/>	Cancer <input type="checkbox"/>	Drug allergies <input type="checkbox"/>	Heart condition <input type="checkbox"/>	Nervous disorders <input type="checkbox"/>	Seizures <input type="checkbox"/>
Allergies <input type="checkbox"/>	Cerebral palsy <input type="checkbox"/>	Endocrine problems <input type="checkbox"/>	Hepatitis <input type="checkbox"/>	Painful chewing <input type="checkbox"/>	Speech problems <input type="checkbox"/>
Anemia <input type="checkbox"/>	Chest pains <input type="checkbox"/>	Emotional disorders <input type="checkbox"/>	High blood pressure <input type="checkbox"/>	Periodontal problems <input type="checkbox"/>	Thumb sucking <input type="checkbox"/>
Arthritis <input type="checkbox"/>	Chronic neck pain <input type="checkbox"/>	Fainting/dizziness <input type="checkbox"/>	Immune problems <input type="checkbox"/>	Pneumonia <input type="checkbox"/>	TMJ problems <input type="checkbox"/>
Asthma <input type="checkbox"/>	Clicking of jaw <input type="checkbox"/>	Finger sucking <input type="checkbox"/>	Kidney problems <input type="checkbox"/>	Pregnant <input type="checkbox"/>	Tongue thrust <input type="checkbox"/>
Autoimmune <input type="checkbox"/>	Cold sores/herpes <input type="checkbox"/>	Glaucoma <input type="checkbox"/>	Mouth breathing <input type="checkbox"/>	Prolonged bleeding <input type="checkbox"/>	Teeth grinding <input type="checkbox"/>
Bone disorders <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Headaches <input type="checkbox"/>	Muscular disorders <input type="checkbox"/>	Rheumatic fever <input type="checkbox"/>	Tuberculosis <input type="checkbox"/>
Any disease, problems, or allergies not mentioned above?			Current Medications?		
Females: Have you started Menstruating?		(Relevant to status of skeletal growth)		At what age?	
Have wisdom teeth been extracted?		Are there any missing or extrateeth?			
Do you normally breathe through the mouth while awake or asleep?		Do you snore?			
Has an orthodontist been consulted previously?		Have you had previous orthodontic treatment?			
Have the tonsils and adenoids been removed?		Any other habit(s)? (nail-biting, lip-biting, etc.)			
Any face, mouth or teeth injuries?			Do gums bleed when brushed or flossed?		

The above information is correct to the best of my knowledge. It is my responsibility to inform you of any changes. I authorize the staff to perform any necessary orthodontic services that I/my child may need during diagnosis and treatment with my informed consent. I understand that I am responsible for payment of services rendered. I understand that you reserve the right to charge for broken appointments or appointments cancelled or changed without 24 hours notice. I understand that credit reports may be obtained at the discretion of this office. I authorize Dr. Dawn S. Wilhite to submit applicable insurance pre-treatment estimates or claims on my behalf.

Signature:	Relationship To Patient:	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Step-Parent <input type="checkbox"/> Self	Date:
Signature:	Relationship To Patient:	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Step-Parent <input type="checkbox"/> Self	Date: