



We would like to welcome you to our office. In an effort to provide the best service possible, we ask you to take a few minutes to fill out this form as completely as possible.

### Patient Information - Adolescent

Name \_\_\_\_\_ Gender \_\_\_\_\_ Preferred Name \_\_\_\_\_  
Address \_\_\_\_\_ Zip \_\_\_\_\_  
Birthdate \_\_\_\_\_ Main Phone \_\_\_\_\_ School \_\_\_\_\_  
Patient resides with  Both Parents  Mother  Father  Step Parent  Shared Custody  Guardian  
Name and ages of other children in your family \_\_\_\_\_  
How did you hear about our office? \_\_\_\_\_ Hobbies \_\_\_\_\_

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### Responsible Party Information

(Person accompanying child to most appointments, making treatment decisions and financially responsible)

Name \_\_\_\_\_ Marital Status \_\_\_\_\_  
Address \_\_\_\_\_ Zip \_\_\_\_\_  
Birthdate \_\_\_\_\_ Social Security \_\_\_\_\_ E-mail \_\_\_\_\_  
Main Phone \_\_\_\_\_ Secondary Phone \_\_\_\_\_ Occupation \_\_\_\_\_

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### Other Guardian Information

(Other parent or step-parent, insurance subscriber or person occasionally accompanying patient to appointments)

Name \_\_\_\_\_ Marital Status \_\_\_\_\_  
Address \_\_\_\_\_ Zip \_\_\_\_\_  
Birthdate \_\_\_\_\_ Social Security \_\_\_\_\_ E-mail \_\_\_\_\_  
Main Phone \_\_\_\_\_ Secondary Phone \_\_\_\_\_ Occupation \_\_\_\_\_

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### Primary Dental Insurance Information

Primary Dental Plan Name \_\_\_\_\_ Insurance Phone No. \_\_\_\_\_  
Policy Holder Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Policy Holder Birthday \_\_\_\_\_ Policy Holder SSN \_\_\_\_\_  
Employer \_\_\_\_\_ Group No. \_\_\_\_\_  
Member/Employee I.D. \_\_\_\_\_ Issue Date \_\_\_\_\_

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### Secondary Dental Insurance Information

Primary Dental Plan Name \_\_\_\_\_ Insurance Phone No. \_\_\_\_\_  
Policy Holder Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Policy Holder Birthday \_\_\_\_\_ Policy Holder SSN \_\_\_\_\_  
Employer \_\_\_\_\_ Group No. \_\_\_\_\_  
Member/Employee I.D. \_\_\_\_\_ Issue Date \_\_\_\_\_

## Dental History

General Dentist Name \_\_\_\_\_ Phone \_\_\_\_\_ Last Visit \_\_\_\_\_

Please select YES or NO for the following questions - Do not leave blank

Y N Speech Problems/Therapy	Y N Pain, Tenderness or Noise in Either Jaw	Y N Mouth Breathing
Y N Grind or Clench Teeth	Y N Oral Habits/Tongue Thrust	Y N Requires Premedication
Y N Injury to Face, Jaw, Teeth or Mouth	Y N Frequent Sore Throats	Y N Food Trapped Between Teeth
Y N Discomfort from Teeth or Gums		Y N Missing/Extra Teeth

If any of the above dental questions were answered 'YES', please explain: \_\_\_\_\_

## Medical History

Physician Name \_\_\_\_\_ Phone \_\_\_\_\_ Last Visit \_\_\_\_\_

Please select YES or NO for the following questions - Do not leave blank

Y N Rheumatic Fever	Y N Low/High Blood Pressure	Y N Nervous Disorders
Y N Tuberculosis/Lung Disease	Y N Blood Disorders	Y N Bone Disorders/Bone Loss
Y N Asthma	Y N HIV/AIDS	Y N Diabetes
Y N Kidney Disease	Y N Hepatitis	Y N Seizures/Epilepsy
Y N Heart Condition	Y N Cancer/Tumor/Cyst	Y N Treated for Emotional Problems
Y N Autism Spectrum Disorder/ ADD/ ADHD	Y N Arthritis	Y N Ever Been Hospitalized
Y N Sleep Breathing Disorder	Y N Endocrine Problems	
	Y N Hormone Therapy	

If any of the above medical questions were answered 'YES', please explain: \_\_\_\_\_

### Y N MEDICATIONS

Please list ANY medications your child is currently taking

\_\_\_\_\_  
\_\_\_\_\_

### Y N ALLERGIES

Please list ANY allergies you are aware of

\_\_\_\_\_  
\_\_\_\_\_

## Orthodontic Consult

Yes No Has your child ever had or been evaluated for orthodontic treatment? If yes, please describe

What are the main concerns that you would like orthodontics to accomplish?

Please list the names of any family or friends currently in the practice

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment. It is my responsibility to inform this office of any changes in my medical status. I will not hold the doctor or staff responsible for any errors or omissions that I have made in the completion of this form.

Parent/Guardian Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_