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NEW PATIENT INFORMATION

(FOR PATIENTS UNDER AGE 18. The information provided is strictly confidential. Please print legibly)

Patient's legal name: _____ Preferred name: _____
Today's date: _____ Birthdate: _____ Age: _____ Sex: M / F
Address: _____ City, State, Zip: _____
Home phone: _____ Email address: _____
Family members or friends currently or previously seen by us: _____
Brothers/Sisters with names/ages: _____
Hobbies/Interests: _____ School/Grade: _____
Previous orthodontic consultation? Yes No If so, when/where? _____
Previous orthodontic treatment? Yes No If so, when/where? _____
In your opinion, what is your orthodontic problem? _____
Who may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

Father's name: _____ Marital Status: S/M/W/D
Address: _____ City, State, Zip: _____
Home phone: _____ Cell/Work #: _____
Birthdate: _____
Employed by: _____ Occupation: _____ Years: _____
Mother's name: _____ Marital Status: S/M/W/D
Address: _____ City, State, Zip: _____
Home phone: _____ Cell/Work #: _____
Birthdate: _____
Employed by: _____ Occupation: _____ Years: _____
If divorce is involved, who is the Custodial Parent? _____
Email address: _____
Do you have orthodontic insurance coverage? Yes No If yes, please fill out insurance form. Thanks!

DENTAL INFORMATION

Dentist's name: _____
Does the patient receive regular checkups? Yes No Last dental exam: _____
Have you been satisfied with the past dentistry? Yes No If No, please explain _____
Does the patient currently have, or have had any of the following? (please check)
 Clenching/Grinding Lip Sucking/Biting Gum Surgery
 Thumb/Finger Sucking Nail Biting Speech Problems
 Tongue Thrust Head/Neck Injury Jaw/Joint Pain/Head/Neck Pain
 Cold Sores Missing or extra permanent teeth

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