

**1. Patient Information:**

First Name: _____ Middle Initials: _____ Last Name: _____

Date of Birth: _____ Gender: Female Male

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Preferred contact method: Mobile Phone Home Phone Work Phone Email None

2. Primary Responsible Party Information:

First Name: _____ Middle Initials: _____ Last Name: _____

Date of Birth: _____ Gender: Female Male Marital Status: Single Married

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Preferred contact method: Mobile Phone Home Phone Work Phone Email Text

3. Secondary Responsible Party Information (optional):

First Name: _____ Middle Initials: _____ Last Name: _____

Date of Birth: _____ Gender: Female Male Other Marital Status: Single Married

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Preferred contact method: Mobile Phone Home Phone Work Phone Email Text

4. How did you learn about our practice or whom may we thank for referring you?

Referral Source

Google Dentist Social Media Sign or billboard Insurance Provider List

Friend or family (enter name)

Other Website

Other

5. What is your primary concern(s)?

6. Has your child had previous orthodontic treatment?

Yes

No

7. General Dentist Information:

Dentist Name:

Dental visit in last 6 months?:

Any scheduled treatments?

Yes No

8. Do you have Orthodontic Insurance?

Yes

No

9. Primary Insurance

Primary Insurance Company

Member ID / Policy #

Group Number

Patient Relationship to Insured

Insured Name

Insured Phone #

Insured Date of Birth

Self Spouse Child

Other

Insured Street Address

Insured City

Insured State

Zip Code

10. Primary Insurance Card: Please take a photo of the back and front of your insurance card. Should treatment be recommended, providing your insurance card will allow us to share the portion of your orthodontic treatment fee covered by your plan.

11. Secondary Dental Insurance

Secondary Insurance Company

Member ID / Policy #

Group Number

Patient Relationship to Insured

Insured Name

Insured Phone #

Insured Date of Birth

Self Spouse Child

Other

Insured Street Address

Insured City

Insured State

Zip Code

12. Secondary Insurance Card: Please take a photo of the back and front of your insurance card. Should treatment be recommended, providing your insurance card will allow us to share the portion of your orthodontic treatment fee covered by your plan.

13. Check if your child has or has had any of the following:

- | | | |
|--|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Asthma/COPD | <input type="checkbox"/> Bleeding abnormally |
| <input type="checkbox"/> Cancer Treatment | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> GERD/Acid Reflux | <input type="checkbox"/> Headaches/Migraines |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> HIV AIDS | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Stroke | <input type="checkbox"/> Tobacco use |
| <input type="checkbox"/> None of the above | | |

Other/Details:

14. Indicate any history of (check all that apply); If checked "Yes", please explain.

- | | | |
|---|---|--|
| <input type="checkbox"/> Thumb/finger sucking | <input type="checkbox"/> Tongue and/or swallowing problems | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Grinding and/or clenching of teeth | <input type="checkbox"/> Tonsils and adenoids removed |
| <input type="checkbox"/> Crowns/Bridges | <input type="checkbox"/> Root canals | <input type="checkbox"/> Mouth breathing |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> History of wearing a mouthguard at night | <input type="checkbox"/> History of Periodontal disease |
| <input type="checkbox"/> History of Periodontal treatment | <input type="checkbox"/> Mouth sores | <input type="checkbox"/> Injury to face or teeth |
| <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Difficulty opening or closing jaw |
| <input type="checkbox"/> Sensitivity when biting | <input type="checkbox"/> Cold, hot, or sweets sensitivity | <input type="checkbox"/> Food collection between certain teeth |
| <input type="checkbox"/> None of the above | | |

Other/Details:

15. Has patient reached puberty?

- Yes No

16. Please list any allergies:

	Allergy
1	

17. List current medications and the correlating diagnosis:

	Medication	Diagnosis
1		

18. Any serious illnesses or operations? If yes, please describe.

19. What treatment option(s) interest you?

- | | | |
|-------------------------------------|---|------------------------------------|
| <input type="checkbox"/> Invisalign | <input type="checkbox"/> Clear/Metal Braces | <input type="checkbox"/> Retainers |
|-------------------------------------|---|------------------------------------|

20. If treatment is recommended, how soon would you like to get started?

- | | | |
|-------------------------------|--|---|
| <input type="checkbox"/> ASAP | <input type="checkbox"/> Within the week | <input type="checkbox"/> Within the month |
|-------------------------------|--|---|

Other:

21. What payment option(s) would you like to review?

- | | | |
|--|---|----------------------------------|
| <input type="checkbox"/> No-Interest Monthly Payment | <input type="checkbox"/> Payment in Full w/Special Courtesy | <input type="checkbox"/> HSA/FSA |
|--|---|----------------------------------|

22. Is there anything else you would like us to know before your visit?:

To the best of my knowledge, the above questions have been accurately answered. I am aware it is my responsibility to inform this office of any changes to my medical status. I permit to perform necessary orthodontic records, and I am aware you may use these records for in-office education.

Signature

Date