

Date _____

All information provided will remain confidential

PATIENT INFORMATION				
Patient's Name _____				
First	Middle	Last		
Physical Address _____				
Street	City	State	Zip Code	
Mailing Address _____				
(if different from above) Street / PO Box _____				
City	State	Zip Code		
Phone _____	Email _____	Birthdate _____	Age _____	Social Security # _____
General Dentist _____		Primary Physician _____		

PRIMARY RESPONSIBLE PARTY INFORMATION				
Relationship <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> _____				
To Patient Other - please explain				
Name _____				
First	Middle	Last		
Marital Status: Single Married Divorced Widow(er)				
Physical Address _____				
Street _____				
City	State	Zip Code		
Mailing Address _____				
(if different from above) Street / PO Box _____				
City	State	Zip Code		
How long at current address? _____ years _____ months				
Previous Address _____				
(if less than 3 years at current address) Street _____				
City	State	Zip Code		
Home Phone _____		Work Phone _____		
Social Security # _____		Birthdate _____		
E-mail _____		Occupation _____		
Employer _____		# of Years _____		

SECONDARY RESPONSIBLE PARTY INFORMATION				
Relationship <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> _____				
To Patient Other - please explain				
Name _____				
First	Middle	Last		
Marital Status: Single Married Divorced Widow(er)				
Physical Address _____				
Street _____				
City	State	Zip Code		
Mailing Address _____				
(if different from above) Street / PO Box _____				
City	State	Zip Code		
How long at current address? _____ years _____ months				
Previous Address _____				
(if less than 3 years at current address) Street _____				
City	State	Zip Code		
Home Phone _____		Work Phone _____		
Social Security # _____		Birthdate _____		
E-mail _____		Occupation _____		
Employer _____		# of Years _____		

DENTAL INSURANCE INFORMATION			
Primary Dental Insurance		Secondary Dental Insurance	
Policy Holder's Name _____		Policy Holder's Name _____	
DOB _____ Social Security # _____		DOB _____ Social Security # _____	
Insurance Company _____		Insurance Company _____	
Group # _____ ID # _____		Group # _____ ID # _____	
Insurance Co. Phone _____		Insurance Co. Phone _____	

EMERGENCY CONTACT INFORMATION			
Name of Nearest Relative not living with you _____			
Address _____			
Street	City	State	Zip Code
			Phone _____

I understand that where appropriate, credit bureau reports may be obtained.

Sign Here

Signature of parent or guardian

Information Updates	
Date	Initial
_____	_____
_____	_____

All information provided will remain confidential

PATIENT DENTAL HISTORY INFORMATION

PATIENT MEDICAL HISTORY INFORMATION

<p>Has the patient seen a dentist in the last 6 months?..... Y N</p> <p>Date of last cleaning _____</p> <p>Any pain, clicking or discomfort in the ears?..... Y N</p> <p>Any serious injury to the patient's mouth, face, teeth?..... Y N</p> <p>Have you been informed of missing or extra permanent teeth?..... Y N</p> <p>Are you aware of any gum problems?..... Y N</p> <p>Has a physician or dentist advised antibiotics before a dental exam?.. Y N</p> <p>Have the patient's tonsils or adenoids been removed?..... Y N</p> <p>Has the patient been examined by an orthodontist before?..... Y N</p> <p>If yes, when? _____</p> <p>Have other members of the family had orthodontic treatment?..... Y N</p> <p>If yes, were you happy with the results?..... Y N</p> <p>If no, why not? _____</p> <p>_____</p> <p>In your own words, what is the orthodontic problem? _____ _____</p> <p>What would you like orthodontic treatment to accomplish? _____ _____</p> <p>_____ Y N</p> <p>Is the patient / are you happy with his / her smile?..... Y N</p> <p>Is the patient comfortable with the idea of wearing braces?..... Y N</p> <p>Has the patient ever had the following habits?</p> <p>Cheek, tongue or lip chewing?..... Y N</p> <p>Sucks thumbs / fingers?..... Y N</p> <p>Mouth breathing?..... Y N</p> <p>Clenches teeth?..... Y N</p> <p>Grinds teeth?..... Y N</p> <p>Tongue thrusting?..... Y N</p> <p>Speech Problems? Y N</p>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">Heart Disease?</td> <td style="width: 10%;">Y</td> <td style="width: 10%;">N</td> <td style="width: 30%;">Hearing Problems?</td> <td style="width: 10%;">Y</td> <td style="width: 10%;">N</td> </tr> <tr> <td>Heart Surgery?</td> <td>Y</td> <td>N</td> <td>HIV Positive?</td> <td>Y</td> <td>N</td> </tr> <tr> <td>Heart Murmur?</td> <td>Y</td> <td>N</td> <td>AIDS?</td> <td>Y</td> <td>N</td> </tr> <tr> <td>Rheumatic Fever?</td> <td>Y</td> <td>N</td> <td>High Blood Pressure?</td> <td>Y</td> <td>N</td> </tr> <tr> <td>Yellow Fever?</td> <td>Y</td> <td>N</td> <td>Low Blood Pressure?</td> <td>Y</td> <td>N</td> </tr> <tr> <td>Scarlet Fever?</td> <td>Y</td> <td>N</td> <td>Tumors or Cancer?</td> <td>Y</td> <td>N</td> </tr> <tr> <td>Rheumatism?</td> <td>Y</td> <td>N</td> <td>Respiratory Disease?</td> <td>Y</td> <td>N</td> </tr> <tr> <td>Arthritis?</td> <td>Y</td> <td>N</td> <td>Measles/Mumps?</td> <td>Y</td> <td>N</td> </tr> <tr> <td>Joint Replacement?</td> <td>Y</td> <td>N</td> <td>Chicken Pox?</td> <td>Y</td> <td>N</td> </tr> <tr> <td>Blood Disease?</td> <td>Y</td> <td>N</td> <td>Polio?</td> <td>Y</td> <td>N</td> </tr> <tr> <td>Liver Disease?</td> <td>Y</td> <td>N</td> <td>Nervous/Emotional?</td> <td>Y</td> <td>N</td> </tr> <tr> <td>Venereal Disease?</td> <td>Y</td> <td>N</td> <td>Diabetes?</td> <td>Y</td> <td>N</td> </tr> <tr> <td>Tuberculosis?</td> <td>Y</td> <td>N</td> <td>Anemia?</td> <td>Y</td> <td>N</td> </tr> <tr> <td>Thyroid Disease?</td> <td>Y</td> <td>N</td> <td>Hemophilia?</td> <td>Y</td> <td>N</td> </tr> <tr> <td>Kidney Disease?</td> <td>Y</td> <td>N</td> <td>Emphysema?</td> <td>Y</td> <td>N</td> </tr> <tr> <td>Fainting/Dizziness?</td> <td>Y</td> <td>N</td> <td>Epilepsy?</td> <td>Y</td> <td>N</td> </tr> <tr> <td>Stomach Disease?</td> <td>Y</td> <td>N</td> <td>Blood Transfusions?</td> <td>Y</td> <td>N</td> </tr> <tr> <td>Intestinal Disease?</td> <td>Y</td> <td>N</td> <td>Asthma / Hay Fever?</td> <td>Y</td> <td>N</td> </tr> <tr> <td>Bone Disease?</td> <td>Y</td> <td>N</td> <td>Broken Bones?</td> <td>Y</td> <td>N</td> </tr> <tr> <td>Endocrine Disease?</td> <td>Y</td> <td>N</td> <td>Prolonged Bleeding?</td> <td>Y</td> <td>N</td> </tr> <tr> <td>Mononucleosis?</td> <td>Y</td> <td>N</td> <td>Yellow Jaundice?</td> <td>Y</td> <td>N</td> </tr> <tr> <td>Hepatitis?</td> <td>Y</td> <td>N</td> <td>Chemical Therapy?</td> <td>Y</td> <td>N</td> </tr> <tr> <td>Fever Blisters?</td> <td>Y</td> <td>N</td> <td>Radiation Therapy?</td> <td>Y</td> <td>N</td> </tr> </table> <p>Is the Patient:</p> <p>Under Medical Care?..... Y N</p> <p>Taking Medication(s)?..... Y N</p> <p>Please list _____</p> <p>Allergies?..... Y N</p> <p>Please list _____</p> <p>Addicted to Drugs?..... Y N</p> <p>Pregnant at this time?..... Y N</p> <p>Currently Smoking?..... Y N</p> <p>Normal Height / Weight?..... Y N</p> <p>Past Puberty?..... Y N</p>	Heart Disease?	Y	N	Hearing Problems?	Y	N	Heart Surgery?	Y	N	HIV Positive?	Y	N	Heart Murmur?	Y	N	AIDS?	Y	N	Rheumatic Fever?	Y	N	High Blood Pressure?	Y	N	Yellow Fever?	Y	N	Low Blood Pressure?	Y	N	Scarlet Fever?	Y	N	Tumors or Cancer?	Y	N	Rheumatism?	Y	N	Respiratory Disease?	Y	N	Arthritis?	Y	N	Measles/Mumps?	Y	N	Joint Replacement?	Y	N	Chicken Pox?	Y	N	Blood Disease?	Y	N	Polio?	Y	N	Liver Disease?	Y	N	Nervous/Emotional?	Y	N	Venereal Disease?	Y	N	Diabetes?	Y	N	Tuberculosis?	Y	N	Anemia?	Y	N	Thyroid Disease?	Y	N	Hemophilia?	Y	N	Kidney Disease?	Y	N	Emphysema?	Y	N	Fainting/Dizziness?	Y	N	Epilepsy?	Y	N	Stomach Disease?	Y	N	Blood Transfusions?	Y	N	Intestinal Disease?	Y	N	Asthma / Hay Fever?	Y	N	Bone Disease?	Y	N	Broken Bones?	Y	N	Endocrine Disease?	Y	N	Prolonged Bleeding?	Y	N	Mononucleosis?	Y	N	Yellow Jaundice?	Y	N	Hepatitis?	Y	N	Chemical Therapy?	Y	N	Fever Blisters?	Y	N	Radiation Therapy?	Y	N
Heart Disease?	Y	N	Hearing Problems?	Y	N																																																																																																																																						
Heart Surgery?	Y	N	HIV Positive?	Y	N																																																																																																																																						
Heart Murmur?	Y	N	AIDS?	Y	N																																																																																																																																						
Rheumatic Fever?	Y	N	High Blood Pressure?	Y	N																																																																																																																																						
Yellow Fever?	Y	N	Low Blood Pressure?	Y	N																																																																																																																																						
Scarlet Fever?	Y	N	Tumors or Cancer?	Y	N																																																																																																																																						
Rheumatism?	Y	N	Respiratory Disease?	Y	N																																																																																																																																						
Arthritis?	Y	N	Measles/Mumps?	Y	N																																																																																																																																						
Joint Replacement?	Y	N	Chicken Pox?	Y	N																																																																																																																																						
Blood Disease?	Y	N	Polio?	Y	N																																																																																																																																						
Liver Disease?	Y	N	Nervous/Emotional?	Y	N																																																																																																																																						
Venereal Disease?	Y	N	Diabetes?	Y	N																																																																																																																																						
Tuberculosis?	Y	N	Anemia?	Y	N																																																																																																																																						
Thyroid Disease?	Y	N	Hemophilia?	Y	N																																																																																																																																						
Kidney Disease?	Y	N	Emphysema?	Y	N																																																																																																																																						
Fainting/Dizziness?	Y	N	Epilepsy?	Y	N																																																																																																																																						
Stomach Disease?	Y	N	Blood Transfusions?	Y	N																																																																																																																																						
Intestinal Disease?	Y	N	Asthma / Hay Fever?	Y	N																																																																																																																																						
Bone Disease?	Y	N	Broken Bones?	Y	N																																																																																																																																						
Endocrine Disease?	Y	N	Prolonged Bleeding?	Y	N																																																																																																																																						
Mononucleosis?	Y	N	Yellow Jaundice?	Y	N																																																																																																																																						
Hepatitis?	Y	N	Chemical Therapy?	Y	N																																																																																																																																						
Fever Blisters?	Y	N	Radiation Therapy?	Y	N																																																																																																																																						

Has the patient had a physical this year? Y N

Are you aware of any other disease, condition, or problem not listed above that we should know about? Y N

If yes, please explain: _____

Request of Release of Records

I, _____ hereby request and give my permission to Roxanne G. Robertson, D.D.S., M.S., P.C. to provide Dentists, Medical Doctors, and / or insurance with any and all information he / she may request with respect to the orthodontic care of _____ . Such records may include medical care and treatment, illness or injury, dental history, medical history, consultation, prescriptions, x-rays, models and copies of all dental records and medical records. I acknowledge receipt of the Notice of Privacy Practices of this office.

Sign Here _____ Date _____

Signature of Patient (if 18 or older)

Sign Here _____ Date _____

Signature of Parent, Legal Guardian or Custodian (if patient under 18)

OFFICE USE ONLY

Medical History Information Updates

I have reviewed the patient's dental and medical history and confirm that it is current and complete.

Signature of Patient or Parent, Legal Guardian or Custodian _____ Date _____
