

Exam Date/Time: _____

New Patient Information *(please write as clearly as possible)*

Today's Date: _____

Patient

Legal Name: _____ Nickname: _____

Birth Date: ____/____/____ Age: _____ Gender at Birth: _____ Pronouns: _____

Phone: Cell _____ Ok to text Home: _____ Email: _____

Address: _____

School: _____ Grade: _____

Whom may we thank for referring you to our office? _____

General Dentist: _____ City: _____

Last cleaning date: _____ X-rays: _____ Perio charting: _____

Current/Previous relative(s) in treatment at our office, Name(s): _____

Chief Concern: _____

Responsible Party

Guardian #1/or Self Name: _____ Email _____

Address: _____

Phone: Cell _____ Ok to text Home: _____ Work _____

Employer: _____ Occupation: _____

Guardian #2/or Partner Name: _____

Address: _____

Phone: Cell _____ Ok to text Home: _____ Work _____

Employer: _____ Occupation: _____

Person financially responsible for this account: _____ Phone: _____

Dental Insurance

Primary

Policy Holder Name: _____ Birth Date ____/____/____ SSN ____ - ____ - ____

Insurance Name: _____ Group No: _____ Employer: _____

Insurance Address: _____ Phone: _____

Coverage: Study Models ____% of \$ ____ max. Tx ____% of \$ ____ max. w/deductible of \$ ____

Secondary Do you have dual coverage? Yes No

Policy Holder Name: _____ Birth Date ____/____/____ SSN ____ - ____ - ____

Insurance Name: _____ Group No: _____ Employer: _____

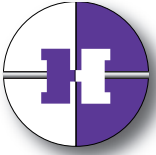
Insurance Address: _____ Phone: _____

Coverage: Study Models ____% of \$ ____ max. Tx ____% of \$ ____ max. w/deductible of \$ ____

Emergency Contact

Name of nearest relative not living with you: _____

Complete Address: _____ Phone: _____



New Patient Health History *(please write as clearly as possible)*

Patient Name: _____

Date: _____

Medical

Is patient in good health? Yes **No**, explain: _____

Name and address of physician: _____

Any serious illness or operation? No **Yes**, explain: _____

Hospitalization or serious illness within the past five years? No

Yes, check all that apply:

Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prolonged bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver involvement	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney involvement	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bone Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	TMJ/TMD Symptoms	<input type="checkbox"/> Yes <input type="checkbox"/> No	Endocrine problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have tonsils and adenoids been removed? Yes No At what age? _____

Allergic to any of the following?

Aspirin / Ibuprofen	<input type="checkbox"/> Yes <input type="checkbox"/> No	Penicillin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Latex, Metal, Plastic	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sulfa Drugs/Sulfites/Sulfides	<input type="checkbox"/> Yes <input type="checkbox"/> No	Codeine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Local Anesthetics	<input type="checkbox"/> Yes <input type="checkbox"/> No

Other: _____

List all medications currently being taken: _____

Dental

Have there been injuries to the face, mouth, or teeth? No **Yes**, explain: _____

Has the patient ever sucked a thumb or finger? Until what age? No **Yes**, explain: _____

Does the patient have any speech problems? No Yes

Have you been informed of any missing or extra permanent teeth? No Yes

Has an orthodontist been consulted previously? No Yes

Has either parent or patient had orthodontic treatment? No Yes

Update to Medical/Dental History: _____

Patient or Guardian Signature: _____

Date _____

Doctor's Signature: _____

Date _____