PATIENT INFORMATION

Today"s Date _____

Patient's name_____ Date of Birth _____

Age _____ Gender M ☐ F ☐ School _____ Grade _____

Mailing Address_____
Street City Zip

Cell phone _____ Email Address _____

Patient's Dentist _____ Referred By _____

FATHER/SPOUSE INFO

Name_____

Address_____

_____

Home phone _____Cell _____

Work phone _____

Email _____

MOTHER/SPOUSE INFO

Name_____

Address_____

_____

Home phone _____Cell _____

Work phone _____

Email _____

Marital Status: Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE:

Subscriber's Name_____ Social Security #_____

Date of Birth _____ Employer _____

Insurance Co._____ Group # _____ Local # _____

Insurance Co. Address_____ Phone # _____

Orthodontic Coverage? Yes ☐ No ☐

Do you have dual coverage? Yes ☐ No ☐

SECONDARY INSURANCE:

Subscriber's Name_____ Social Security #_____

Date of Birth _____ Employer _____

Insurance Co._____ Group # _____ Local # _____

Insurance Co. Address_____ Phone # _____

Orthodontic Coverage? Yes ☐ No ☐

PERSON RESPONSIBLE FOR ACCOUNT

Name _____ Relation to patient _____

Phone/Address (If different from patient/parent) _____

MEDICAL HISTORY

Yes	No		Yes	No	
☐	☐	Do you have a history of major illness?	☐	☐	Have you ever had unusual reactions to any drug?
☐	☐	Are you currently taking any medications?	☐	☐	Are you allergic to any foods or medications?
☐	☐	Are you allergic to or sensitive to Latex?	☐	☐	Do you have any bleeding disorders?

If you answered YES to any of the above, please explain _____

_____

Female Patients: Are you pregnant? Yes ☐ No ☐ Do you take Bisphosphonate bone supplement meds? Yes ☐ No ☐

Circle any of the medical conditions below that you have had or currently have:

Anemia Hemophilia Blood Disease Diabetes Hepatitis/Liver Disease Chronic Sinus Infection Dizziness

Herpes/Cold Sores Prolonged Bleeding Arthritis Epilepsy High Blood Pressure Radiation/Chemotherapy

Asthma Hearing loss Rheumatic Fever Bone Disorders Heart Murmur Kidney Disease Endocrine Disorder

Tuberculosis Congenital Heart Defect Cancer Heart Disease Thyroid Disorder Eating Disorder HIV / Aids

Other _____

DENTAL HISTORY

Yes	No	
☐	☐	Is the patient a mouth breather?
☐	☐	Has the patient had tonsils or adenoid removed? If so, at what age _____
☐	☐	Has the patient had head or facial injuries?
☐	☐	Does the patient play a musical instrument? If so, what kind _____
☐	☐	Has the patient had a thumb sucking or finger sucking habit? Is it currently active? _____
☐	☐	Do your gums bleed when you brush/floss?

Does the patient have a history of any of the following:

Yes	No	
☐	☐	Clenching or grinding teeth
☐	☐	Muscle soreness in the head or neck
☐	☐	Frequent or recurring headaches
☐	☐	Jaw joint clicking or popping
☐	☐	Jaw joint locking
☐	☐	Jaw joint soreness

What do you think is the patient's orthodontic problem? _____

_____

Have any immediate family members had orthodontic treatment? Yes ☐ No ☐

With Dr. Charchut? Yes ☐ No ☐ If yes, please list names: _____

_____

Please make any comments that you feel may be helpful: _____

_____

_____

Signature:_____ Date:_____