



Patient Information

Today's Date _____

Patient's Name _____ Nick name _____

Address _____ City _____ Zip _____

Email Address _____ Home Phone _____ Cell Phone _____

SSN _____ DOB ____/____/____ Age _____ Sex _____

School _____ Grade _____ Hobbies/Interests _____

General/Pediatric Dentist _____ City _____ Last Visit _____

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

Siblings: Name/Age _____

Responsible Party Information

Father's Name _____ Biological Other _____

Address _____ City _____ How Long? _____

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security Number _____ - _____ - _____ DOB ____/____/____

Employer _____ Occupation _____ How Long? _____

Mother's Name _____ Biological Other _____

Address _____ City _____ How Long? _____

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security Number _____ - _____ - _____ DOB ____/____/____

Employer _____ Occupation _____ How Long? _____

Person financially responsible for this account _____

Orthodontic Insurance Information

Primary Dental Insurance Orthodontic Coverage Yes No

Insured's Name _____ Relation _____ Employer _____

DOB ____/____/____ SSN _____

Insurance Company _____ Group No. _____ Insurance IDN _____

Insurance Company Address _____ City _____ Zip _____

Insurance Company Phone _____

Do you have dual coverage? Yes? No

Secondary Dental Insurance Orthodontic Coverage ? Yes No

Insured's Name _____ Relation: _____ Employer: _____

DOB ____/____/____ SSN _____

Insurance Company _____ Group No. _____ Insurance IDN _____

Insurance Company Address _____ City _____ Zip _____

Insurance Company Phone _____

Emergency Information

Contact Person _____ Relation _____ Phone _____

Medical History

Physician's Name _____ Last Visit _____ Phone Number _____

Current physical condition Good Fair ? Poor Currently under the care of a physician? Yes No

Ever been under the care of a physician for a major illness? Yes No _____

Please answer all questions by checking 'Yes' or 'No'.

Good Health	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Recent illness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prolonged bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No
Recent cold, cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart or chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle cell anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint replacement	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lung disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hay fever, seasonal allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nasal obstruction	<input type="checkbox"/> Yes <input type="checkbox"/> No
Herpes (cold sores)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Severe headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
AIDS or HIV positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bone disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Endocrine disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Growth disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Canker Sores	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tonsils/Adenoids removed	<input type="checkbox"/> Yes <input type="checkbox"/> No	Antibiotics required for	
Still Growing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dental appointments	<input type="checkbox"/> Yes <input type="checkbox"/> No

List any drugs (prescription and over the counter) that currently taking and please give reason _____

List any allergies or sensitivities including drug, latex metal or other _____

Has patient reached puberty? Girl – Started Menstruation Yes No _____

Boy – Voice Changed/Facial hair Yes No _____

Dental History

What is the main concern you would like orthodontics to accomplish? _____

Current Dental Health Good Fair Poor

Has an orthodontist been consulted previously? Yes No Have you ever been treated with orthodontics before?

Yes No If yes, please explain: _____

Family history of orthodontic treatment Yes No _____

Has the patient ever sucked a thumb or finger? Yes No If yes, until what age? _____

Has your child ever experienced pain / discomfort in your jaw joint (TMJ/TMD)? Yes No

Does your child have a tongue thrust? Yes No Any history of speech problems? Yes No

Has your child ever had injuries to your face, mouth, teeth or chin? Yes No

Does your child generally breath through their mouth? Awake: Yes No Asleep Yes No

Does your child have any missing or extra permanent teeth? Yes No _____

I have read and understand the above questions. I will not hold Dr. Newman or and member of his staff responsible for any errors or omissions that I have made in completion of this form. If there are any changes to this history record or medical/dental status, I will so inform this practice.

Signature _____ Date _____