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**Patient Information**

Date \_\_\_\_\_ Adult  Minor   
Patient's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ M F  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_  
If patient is a minor, give custodial parents or legal guardian's name \_\_\_\_\_  
Whom may we thank for referring you to our office? \_\_\_\_\_  
What is your chief concern with your (or child's) teeth? \_\_\_\_\_

**Responsible Information/Primary Insurance**

Marital Status:  Married  Separated  Divorced  Widowed  Single  
Name \_\_\_\_\_ Email \_\_\_\_\_  
Residence \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
How long at this address \_\_\_\_\_ Home phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  
Previous Address (if less than 3 yrs) \_\_\_\_\_  
Employer \_\_\_\_\_ Addr \_\_\_\_\_ Phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_  
Subscriber ID# \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_  
Phone \_\_\_\_\_ Ins. Auth Signature \_\_\_\_\_  
(Office to Fill out) Benefits Max \_\_\_\_\_ % \_\_\_\_\_ Age \_\_\_\_\_ Payment Sch \_\_\_\_\_

**SPOUSE AND/OR SECONDARY INS COVERAGE**

Name \_\_\_\_\_ Email \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
Employer \_\_\_\_\_ Addr \_\_\_\_\_ Phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_  
Subscriber ID# \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_  
Phone \_\_\_\_\_ Ins. Auth Signature \_\_\_\_\_  
(Office to Fill out) Benefits Max \_\_\_\_\_ % \_\_\_\_\_ Age \_\_\_\_\_ Payment Sch \_\_\_\_\_

**Emergency Contact**

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_  
Relationship to patient \_\_\_\_\_

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

Signature (Parent's signature if minor) \_\_\_\_\_

Updates (date and initial) \_\_\_\_\_

Patient \_\_\_\_\_  
Physician \_\_\_\_\_ City \_\_\_\_\_ Phone \_\_\_\_\_

Does the patient:

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Have any health problems? Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Take any medications? List _____
<input type="checkbox"/>	<input type="checkbox"/>	Have allergic reactions to medications? List _____
<input type="checkbox"/>	<input type="checkbox"/>	Currently see a physician? Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Receive blood transfusion? Reason _____
<input type="checkbox"/>	<input type="checkbox"/>	Had their tonsils and adenoids removed? When _____
<input type="checkbox"/>	<input type="checkbox"/>	Take medication for immunosuppressive disease? Explain _____

Take any medications for dietary conditions? i.g. phenphen \_\_\_\_\_  
  Are you currently or ever taken bisphosphonates? Explain \_\_\_\_\_

**Please check if patient has had any of the following:**

	Yes	No		Yes	No		Yes	No
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Hives/Rash	<input type="checkbox"/>	<input type="checkbox"/>	Emotional Problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Nervous/Anxious	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Bone Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Growth Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Herpes (Fever Blisters)	<input type="checkbox"/>	<input type="checkbox"/>
Developmental Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>

Any other conditions or problems that we should know about? \_\_\_\_\_

**Growth information for patients under 16-** Because growth can be an important factor in orthodontic treatment planning, your answers to the following questions are needed to aid our treatment alternatives: Has patient:

Reached puberty  Yes  No  
 Girls- started menstruation?  Yes  No When? \_\_\_\_\_  
 Boys- Voice changed?  Yes  No When? \_\_\_\_\_  
 Do you feel growth is completed?  Yes  No Father's Height \_\_\_\_\_ Mother's Height \_\_\_\_\_  
 Have siblings or parents been treated with orthodontics?  Yes  No

**Dentist** \_\_\_\_\_ **City** \_\_\_\_\_ **Phone** \_\_\_\_\_

Frequency of dental checkups: Twice a yr  Once a yr  Only if problem exists  Never  Date of last visit \_\_\_\_\_  
 Is there any unfinished care to be completed with your dentist?  Yes  No Explain: \_\_\_\_\_  
 Are you frightened about dental treatment?  Yes  No Explain: \_\_\_\_\_  
 Have you had any unpleasant experience in a dental office?  Yes  No Explain: \_\_\_\_\_  
 Have you had any face or dental injuries?  Yes  No Explain: \_\_\_\_\_  
 Do you play any musical instrument?  Yes  No What instrument? \_\_\_\_\_  
 Have you consulted with an orthodontist previously?  Yes  No With whom? \_\_\_\_\_  
 Have teeth (either primary or permanent) been removed?  Yes  No Explain: \_\_\_\_\_  
 Have you had any previous orthodontic treatment?  Yes  No With whom? \_\_\_\_\_  
 Are you satisfied with prior treatment?  Yes  No Explain: \_\_\_\_\_  
 Is there a history of thumb sucking?  Yes  No How long: \_\_\_\_\_

Please check if there is a history of:

<input type="checkbox"/> Clenching teeth	<input type="checkbox"/> Muscular soreness around head and neck	<input type="checkbox"/> Jaw joint soreness	<input type="checkbox"/> Jaw joint popping
<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Headaches (more than normal)	<input type="checkbox"/> Jaw joint clicking	<input type="checkbox"/> Ringing in ears
<input type="checkbox"/> Speech problems (If so, what sounds _____)		<input type="checkbox"/> Mouth breathing: circle	<b>awake asleep</b>

Is there any other information that may be helpful? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Parent/Guardians signature (if minor) \_\_\_\_\_

**For Office Use Only**

T.C.'s Initials \_\_\_\_\_ Dr. Iverson \_\_\_\_\_ Date \_\_\_\_\_  
 Update \_\_\_\_\_ Dr. Iverson \_\_\_\_\_ Date \_\_\_\_\_