A B C

PATIENT INFORMATION

Date___________________Gender M F Birthdate__________ Age____

Patient's name____
Last First Middle

Address ____
Street City Zip

Home Phone______________________ Social Security # ___________________________________

If patient is a minor, give parent's or guardian's name ______________________________

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

RESPONSIBLE PARTY INFORMATION

Father's Name____
Last First Middle

Marital Status Married Single Divorced Birthdate____________________ Social Security # ____________________

Father's Employer________________________________ Occupation______________Number years employed_______

Home phone_______________________ Work phone____________________Cell/other _________ ____________________

Email address ____

Mother's Name ____
Last First Middle

Marital Status Married Single Divorced Birthdate_______________ Social Security # _________________________

Mother's Employer________________________________ Occupation______________Number years employed_______

Home phone_______________________ Work phone____________________Cell/other _________ ____________________

Email address ____

DENTAL INSURANCE INFORMATION

Insured's Name_____________________________ Insured's Social Security________ Insured's Birthdate ___________

Insurance Company__________________________ Group No._________________ Local No._____________________

Insurance Co. Address____ Phone No. __________________

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name________________ Insured's Social Security_______________________ Insured's Birthdate ________

Insurance Company__________________________ Group No._________________ Local No._____________________

Insurance Co. Address____ Phone No. __________________

EMERGENCY INFORMATION

Name of nearest relative not living with you _______________________________________

Complete address ____
Street City Zip

Phone ____

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

Signature (Parent's signature if minor) ____

MEDICAL HISTORY

Physician ______________________________ Date of Last Visit ______________________
Address ______________________________ Phone ______________________
Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? ______________________
Yes No Are you allergic to any medication? ______________________

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

Rheumatic Fever	Heart Ailment	High or Low Thyroid
Asthma or Hayfever	Diabetes	Blood Transfusion
High Blood Pressure	Tonsils or Adenoids removed	

Are there any medical conditions we have not discussed that you feel we should be aware of? ______________________
____

DENTAL HISTORY

General Dentist ______________________________ Date of last visit ______________________
What concerns you most about your teeth? ______________________

Yes No Are you presently in any dental pain? ______________________
Yes No Have you ever lost or chipped any teeth? ______________________
Yes No Have there been any injuries to face, mouth, or teeth? ______________________
Yes No Is any part of your mouth sensitive to temperature? Where? ______________________
Yes No Is any part of your mouth sensitive to pressure? Where? ______________________
Yes No Do your gums bleed when you brush? ______________________
Yes No Have you ever seen an orthodontist? If yes, who and when? ______________________
What is your attitude toward receiving orthodontic treatment? ______________________
Yes No Has anyone in your family received orthodontic treatment with us? ______________________
How did they feel about the result? ______________________
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? ______________________
Yes No Are you aware of your jaw clicking or popping? ______________________
Yes No Are you aware of clenching your teeth during the day? ______________________
Yes No Have you ever been told that you grind your teeth? ______________________
Yes No Do you have "tension" headaches? ______________________
Yes No Have you ever experienced chronic ringing in your ears? ______________________
Yes No If the patient is under age 16, height of parents? Mom______ Dad______
Yes No Any noticeable difficulty in breathing through nose? ______________________
Yes No Do you have speech problems? ______________________
Yes No Do you have any type of thumb or tongue habit? ______________________
Yes No Are you a mouth breather? ______________________

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Kirby Nelson Orthodontics to perform a complete orthodontic evaluation.

Signature: ______________________________ Date: ______________________