Date_____

Patient's Name_____

Last First Middle

Address_____

Street City Zip

Nickname_____ Birthdate_____ Social Security #_____

School_____ Sports/Hobbies_____

Parent or guardian name_____

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

**RESPONSIBLE PARTY INFORMATION**

Name_____

Last First Middle

Residence_____

Street City Zip

Mailing Address_____

Street City Zip

How long at this address?_____ Home phone_____ Work phone_____

Cell/other phone_____ Email address_____

Previous Address (If less than 3 years)_____

Social Security #_____ Birthdate_____ Relationship to Patient_____

Employer_____ Occupation_____ No. years employed_____

Spouse's Name_____ Relationship to Patient_____

Employer_____ Occupation_____ No. years employed_____

Social Security #_____Birthdate_____Work Phone_____

**DENTAL INSURANCE INFORMATION**

Insured's Name_____ Insured's Social Security #_____

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 #_____

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.

Parent Signature _____

Updates (date & Initial)_____

## MEDICAL HISTORY

Physician_____Date of Last Visit_____
Address_____Phone_____
Please circle Yes or No (If Yes, please fill in details)
Yes No Is the patient taking any medication? _____
Yes No Is the patient allergic to any medication? _____
Yes No History of a major illness?_____
Yes No Has the patient had any operations?_____
Yes No Ever been involved in a serious accident?_____
Yes No Have seen a physician in the last 12 months? Why?_____
Female Patients only:
Yes No Has menstruation started?_____
Yes No Is the patient pregnant?_____
Circle any of the medical conditions below that the patient has had or currently has.
Abnormal bleeding/Hemophilia Diabetes Hepatitis/Liver problems Pneumonia
Anemia Dizziness Herpes Prolonged Bleeding
Arthritis Epilepsy High Blood Pressure Radiation/Chemotherapy
Asthma or Hayfever Gastrointestinal Disorders HIV / Aids Rheumatic Fever
Bone Disorders Heart Problems Kidney problems Tuberculosis
Congenital Heart Defect Heart Murmur Nervous Disorders Tumor or Cancer
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 Is the patient presently in any dental pain?_____
Yes No Ever experienced any unfavorable reaction to dentistry?_____
Yes No Has the patient 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 gums bleed when brushing?_____
Yes No Any type of thumb or tongue habit?_____
Yes No Is the patient a mouth breather?_____
Yes No Has the patient ever seen an orthodontist? If yes, who and when?_____
Yes No What is the patient's attitude toward receiving orthodontic treatment?_____
Yes No Has anyone in the family received orthodontic treatment?How did they feel about the result?_____
Yes No Do teeth or jaws ever feel uncomfortable first thing in the morning?_____
Yes No Experience jaw clicking or popping?_____
Yes No Aware of clenching or grinding teeth during the day?_____
Yes No Experience "tension" headaches?_____
Yes No Has the patient ever experienced chronic ringing in the ears?_____
Yes No Does the patient need extra help with instructions?_____
Yes No Is the patient sensitive or self-conscious about his/her teeth?_____
Yes No Height of parents? Mom_____ Dad_____
Yes No Are you aware that some appointments will be during school hours?_____

## 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 ***Dr. Rubensteen*** to perform a complete orthodontic evaluation.

Signature:_____Date:_____