



NAME YOU WANT TO BE CALLED \_\_\_\_\_

NAMES OF OTHER FAMILY MEMBERS WE TREATED \_\_\_\_\_

NAMES AND AGES OF OTHER CHILDREN IN THE FAMILY \_\_\_\_\_

### PATIENT INFORMATION

PATIENT'S NAME \_\_\_\_\_ DATE \_\_\_\_\_  
Last First Middle

ADDRESS \_\_\_\_\_  
Street City State Zip

HOME PHONE \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ PATIENT'S SCHOOL \_\_\_\_\_

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

NAME \_\_\_\_\_  
Last First Middle

RESIDENCE \_\_\_\_\_  
Street City State Zip

MAILING ADDRESS \_\_\_\_\_  
Street City State Zip

HOW LONG AT THIS ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

PREVIOUS ADDRESS (IF LESS THAN 3 YRS.) \_\_\_\_\_  
Street City State Zip

*Email* SOCIAL SECURITY # \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_ NO. YEARS EMPLOYED \_\_\_\_\_

SPOUSE'S NAME \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_  
Last First Middle

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_ NO. YEARS EMPLOYED \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

### DENTAL HISTORY

PATIENT'S DENTIST \_\_\_\_\_ LAST SEEN \_\_\_\_\_ YES NO

HAVE THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH? \_\_\_\_\_

HAS THE PATIENT EVER SUCKED A THUMB OR FINGER? \_\_\_\_\_ UNTIL WHAT AGE? \_\_\_\_\_

DOES THE PATIENT HAVE ANY CLICKING OR DISCOMFORT IN JAW JOINTS NEAR EARS? \_\_\_\_\_

HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH? \_\_\_\_\_

HAS THE PATIENT HAD ANY PREVIOUS ORTHODONTIC EXAMINATIONS? \_\_\_\_\_

DOES THE PATIENT CLENCH OR GRIND HIS/HER TEETH? \_\_\_\_\_

IS THE PATIENT ESPECIALLY APPREHENSIVE TOWARD DENTAL VISITS? \_\_\_\_\_

DOES THE PATIENT HAVE ANY CONGENITAL ABNORMALITIES? \_\_\_\_\_

LIST SPORTS AND INTEREST \_\_\_\_\_