PATIENT INFORMATION *****PLEASE PRINT***** Email _____

Date_____ MALE_____ FEMALE_____

PATIENT'S FULL NAME_____PREFERRED NAME_____

MAILING ADDRESS_____

CITY_____STATE_____ZIP CODE_____

PRIMARY PHONE #_____BIRTHDATE_____SS#_____

EMPLOYER_____ OCCUPATION _____

WHOM MAY WE THANK FOR REFERRING TO OUR OFFICE? _____DENTIST_____

NAME OF OTHER FAMILY MEMBERS WE TREATED_____

WHAT IS YOUR PRIMARY CONCERN? _____

PARENT / GUARDIAN INFORMATION IF THE PATIENT IS UNDER 18 YEARS OLD

MOTHER _____ DATE OF BIRTH_____PHONE #_____

MAILING ADDRESS_____CITY_____STATE_____ZIP_____

EMPLOYER_____OCCUPATION_____

FATHER_____DATE OF BIRTH_____PHONE #_____

MAILING ADDRESS_____CITY_____STATE_____ZIP_____

EMPLOYER_____OCCUPATION_____

GUARDIAN NAME_____PHONE #_____

WHICH PARENT OR GUARDIAN DO YOU LIVE WITH? _____

WHO IS PRIMARILY RESPONSIBLE FOR THE FINANCIAL ACCOUNT? _____

(FINANCIAL RESPONSIBLE PARTY WILL NEED TO BE PRESENT TO SIGN THE CONTRACT)

ORTHODONTIC INSURANCE INFORMATION (NO MEDICAL)

NAME OF INSURANCE_____POLICY HOLDER_____

POLICY HOLDER'S BIRTHDAY_____POLICY HOLDER'S SS#_____

EMPLOYER_____

We do not participate with insurance. We will file your insurance as a convenience for you. It is your responsibility to supply us with a copy of your insurance card, a filled out direct reimbursement form, or your flex spending account information. NOTE: Our office cannot guarantee insurance coverage or payment, nor can our office be responsible if insurance does not pay.

EMERGENCY CONTACT OR ADDITIONAL FAMILY MEMBERS

NAME_____PHONE #_____RELATIONSHIP_____

NAME_____PHONE #_____RELATIONSHIP_____

Please Return
Completed Form

Name: _____ **MEDICAL HISTORY**

Has The Patient Ever Been Treated For Any Of The Following: (Please Circle)

Diabetes	**Tuberculosis**	**Endocrine or Thyroid**	**Depression**
Pneumonia	**Anemia**	**Prolonged Bleeding**	**TMJ/TMD**
Rheumatic Fever	**Asthma**	**Fainting or Dizziness**	**Osteoporosis**
Heart Trouble	**Epilepsy**	**Liver Problems**	**Hepatitis**
Bone Disorders	**Kidney Problems**	**Nervous Disorders**	**Migraines**
Arthritis	**AIDS or HIV positive**	**High Blood Pressure**	**ADD/ADHD**

Is the Patient in good health?_____

Females: Are you (The Patient) **Pregnant?** (Please circle one) Yes No

Does the Patient have any history of Major Illness / or Major Surgeries?_____

List any drugs or medications now being taken. Give reasons_____

Does patient need to be pre-medicated: Yes No _____

List any Drug Sensitivities / Allergies:_____

Please Circle if the Patient is Allergic to: **Metals** (jewelry, clothing snaps) **Latex** (gloves, balloons) **Vinyl** **Acrylic**

Have Tonsils and Adenoids been removed? What age?_____

Growth in the past 6 months_____Has Patient reached puberty?_____

Height: Patient's_____ Mother's_____Father's_____

Patient's Physician_____ Last seen_____

I have read and understand the above questions. I will not hold my orthodontist or any member of Dr. Holly Cantrell's staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice. Signature:_____Date:_____

DENTAL HISTORY

Have there been any injuries to the face, mouth or teeth? If yes, when?_____

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?_____

Patient's Dentist_____Last seen_____

List sports and interests_____

Please Return Completed Form