Today's date: _____ Name: _____

Date of birth: _____ Sex: Male or Female

Address:_____

City:_____ State: _____ Zip:_____

Home#: _____ Mobile#: _____

Email address:_____

Employer:_____ Work# _____

PRIMARY INSURANCE:

Policy holder's name: _____ Date of birth: _____

Name of insurance: _____ Employer name: _____

SSN:_____ ID#_____ Group#_____

SECONDARY INSURANCE:

Policy holder's name: _____ Date of birth: _____

Name of insurance: _____ Employer name: _____

SSN:_____ ID#_____ Group#_____

DENTAL HISTORY:

Dentist's Name: _____

When was your last exam and cleaning? _____

1.) Do your gums bleed when brushing? Yes or No

2.) Have you ever been told that you have Periodontal Disease? Yes or No

3.) Are you currently seeing a Periodontist for your cleanings? Yes or No

4.) Do you have any clicking, popping or pain in the jaw joint? Yes or No

5.) Do you clench or grind your teeth? Yes or No

6.) Do you have any problems opening or closing your mouth? Yes or No

7.) Have you ever injured or had trauma to your teeth, face or jaw? Yes or No If yes, please explain:_____

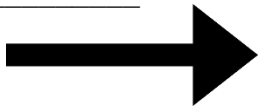
_____

8.) Have you ever had prior orthodontic treatment in the past? Yes or No If yes, do you have a retainer that you are still wearing? Yes or No

9.) Are your wisdom teeth still present? Yes or No

10.) Are you interested in whitening your teeth? Yes or No

11.) Have you been advised by your physician to take an antibiotic prior to dental treatment? Yes or No If yes, please explain: _____



12.) Is there dental work that is in progress or needs to be completed? Yes or No

13.) What is your main concern about your teeth? _____

_____

14.) Would you like to see changes with your facial appearance with orthodontics? Yes or No If yes, please explain: _____

15.) Are you interested in braces? Yes or No Invisalign? Yes or No

MEDICAL HISTORY:

Physician's Name: _____

1). Do you have health problems, disorders or conditions? Yes or No If yes explain:

_____

3). Do you have any allergies to medications? Yes or No If yes, please list:

_____

4). Allergic to LATEX? Yes or No Environmental: (Dust, Pollen, or Mold) Yes or No

5). Medications that you are CURRENTLY taking: _____

_____

6.) Are there any facial features that you would like to see changed after completing orthodontic treatment? Yes or No If yes, please list: _____

PATIENT'S HEALTH HISTORY:

Birth problems……..	Yes or No	Emotional or Behavior problems….	Yes or No
Speech problems…….	Yes or No	Hearing problems……..	Yes or No
Tonsil/Adenoid problems.	Yes or No	Growth problems……	Yes or No
Attention Deficit Disorder…	Yes or No	Heart Murmur……..	Yes or No
Diabetes……..	Yes or No	Rheumatic Fever……..	Yes or No
Arthritis……	Yes or No	Anemia……..	Yes or No
Cancer……	Yes or No	Radiation Therapy……	Yes or No
Sickle Cell Anemia…….	Yes or No	Cerebral Palsy……..	Yes or No
Bleeding or Hemophilia……	Yes or No	Seizures……..	Yes or No
Blood Transfusions……	Yes or No	Asthma……..	Yes or No
Hepatitis……..	Yes or No	Cleft Lip or Palate……	Yes or No
AIDS or HIV+……	Yes or No	Eye problems……	Yes or No
Tuberculosis……....	Yes or No	Liver Disease……	Yes or No
Sleep Apnea……..	Yes or No	Kidney Disease……	Yes or No
Osteoporosis……..	Yes or No	Skin problems……	Yes or No

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