



Welcome to our practice!

Patient's Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
 Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ Sex: Male / Female  
 Home Address: \_\_\_\_\_ City, State and Zip Code: \_\_\_\_\_  
 How long at this address? \_\_\_\_ Mailing address same as above? Y / N If no, please specify: \_\_\_\_\_  
 Social Security No: \_\_\_\_\_ Email Address: \_\_\_\_\_  
 Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_  
 Brothers/Sisters or Sons/Daughters (names & ages): \_\_\_\_\_  
 School/Grade: \_\_\_\_\_ Interests/Hobbies: \_\_\_\_\_  
 Whom may we thank for referring you to our office? \_\_\_\_\_

**Responsible Party Information**

Father's Name: \_\_\_\_\_ Marital Status: Single / Married / Separated / Widowed / Divorced  
 Address: \_\_\_\_\_ City, State and Zip Code: \_\_\_\_\_  
 Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_  
 Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security No: \_\_\_\_\_ Driver's Lic. No.: \_\_\_\_\_  
 Employed By: \_\_\_\_\_ For how long? \_\_\_\_ Occupation: \_\_\_\_\_  
 Orthodontic insurance coverage? Yes / No **\*\*If yes, please complete insurance portion\*\***

Mother's Name: \_\_\_\_\_ Marital Status: Single / Married / Separated / Widowed / Divorced  
 Address: \_\_\_\_\_ City, State and Zip Code: \_\_\_\_\_  
 Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_  
 Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security No: \_\_\_\_\_ Driver's Lic. No.: \_\_\_\_\_  
 Employed By: \_\_\_\_\_ For how long? \_\_\_\_ Occupation: \_\_\_\_\_  
 Orthodontic insurance coverage? Yes / No **\*\*If yes, please complete insurance portion\*\***

**Dental Insurance Information**

Insured's Name: \_\_\_\_\_ Social Security: \_\_\_\_\_  
 Insurance Company: \_\_\_\_\_ Group No.: \_\_\_\_\_  
 Insurance Co. Address: \_\_\_\_\_ Phone No.: (\_\_\_\_) \_\_\_\_\_  
 Insured's Employer: \_\_\_\_\_ Employer Address, City & Zip: \_\_\_\_\_  
 Is this the primary insurance for the patient? Yes / No **\*\*If there is dual coverage, please complete secondary info\*\***

**\*\*SECONDARY\*\*** Insured's Name: \_\_\_\_\_ Social Security: \_\_\_\_\_  
 Insurance Company: \_\_\_\_\_ Group No.: \_\_\_\_\_  
 Insurance Co. Address: \_\_\_\_\_ Phone No.: (\_\_\_\_) \_\_\_\_\_  
 Insured's Employer: \_\_\_\_\_ Employer Address, City & Zip: \_\_\_\_\_

**Emergency Contact**

Name of nearest relative not living with you: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
 Address, City, State and Zip Code: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

## Medical History

Physician Name: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Address: \_\_\_\_\_ Phone No.: (\_\_\_\_) \_\_\_\_\_

Please check Yes or No for the questions below. If yes, please fill in details:

- |                           |                          |   |
|---------------------------|--------------------------|---|
| <input type="radio"/> Yes | <input type="radio"/> No | Are you taking any medications? _____                               |
| <input type="radio"/> Yes | <input type="radio"/> No | Are you allergic to any medications? _____                          |
| <input type="radio"/> Yes | <input type="radio"/> No | Do you have a history of a major illness? _____                     |
| <input type="radio"/> Yes | <input type="radio"/> No | Have you had any operations? _____                                  |
| <input type="radio"/> Yes | <input type="radio"/> No | Have you ever been involved in a serious accident? _____            |
| <input type="radio"/> Yes | <input type="radio"/> No | Have you ever smoked or chewed tobacco? _____                       |
| <input type="radio"/> Yes | <input type="radio"/> No | Have you seen a physician in the last 12 months? If yes, why? _____ |

For female patients:

- |                           |                          |                           |
|---------------------------|--------------------------|---------------------------|
| <input type="radio"/> Yes | <input type="radio"/> No | Are you pregnant?         |
| <input type="radio"/> Yes | <input type="radio"/> No | Has menstruation started? |

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

Abnormal Bleeding/Hemophilia	Diabetes	Hepatitis/Liver Problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemo
Asthma/Hay Fever	Gastrointestinal Problems	HIV/AIDS	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney Problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

## Dental History

General Dentist: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**\*\*Please tell us what concerns you most about your teeth:** \_\_\_\_\_

- |                           |                          |   |
|---------------------------|--------------------------|---|
| <input type="radio"/> Yes | <input type="radio"/> No | Are you presently in any dental pain?   |
| <input type="radio"/> Yes | <input type="radio"/> No | Have your wisdom teeth been removed?  |
| <input type="radio"/> Yes | <input type="radio"/> No | Have you ever lost or chipped any teeth?  |
| <input type="radio"/> Yes | <input type="radio"/> No | Have there been any injuries to face, mouth or teeth?                               |
| <input type="radio"/> Yes | <input type="radio"/> No | Is any part of your mouth sensitive to temperature? If so, where? _____             |
| <input type="radio"/> Yes | <input type="radio"/> No | Is any part of your mouth sensitive to pressure? If so, where? _____                |
| <input type="radio"/> Yes | <input type="radio"/> No | Do your gums bleed when you brush?  |
| <input type="radio"/> Yes | <input type="radio"/> No | Have you ever experienced any unfavorable reaction to dentistry? If so, what? _____ |
| <input type="radio"/> Yes | <input type="radio"/> No | Do you have any type of thumb or tongue habit?                                      |
| <input type="radio"/> Yes | <input type="radio"/> No | Are you a mouth breather?   |
| <input type="radio"/> Yes | <input type="radio"/> No | Do your teeth or jaws ever feel uncomfortable when you wake in morning?             |
| <input type="radio"/> Yes | <input type="radio"/> No | Are you aware of your jaw clicking or popping?                                      |
| <input type="radio"/> Yes | <input type="radio"/> No | Are you aware of clenching your teeth during the day?                               |
| <input type="radio"/> Yes | <input type="radio"/> No | Have you ever been told that you grind your teeth?                                  |
| <input type="radio"/> Yes | <input type="radio"/> No | Do you have "tension" headaches?  |
| <input type="radio"/> Yes | <input type="radio"/> No | Have you ever experienced chronic ringing in your ears?                             |
| <input type="radio"/> Yes | <input type="radio"/> No | Have you ever seen an orthodontist? If yes, who and when? _____                     |
|                           |                          | What is your attitude toward receiving orthodontic treatment? _____                 |
| <input type="radio"/> Yes | <input type="radio"/> No | Has anyone in your family received orthodontic treatment? If so, who? _____         |
|                           |                          | How did they feel about the results? _____  |
| <input type="radio"/> Yes | <input type="radio"/> No | Are you aware that some appointments will be during work/school hours?              |

**Benefits of Orthodontics:** Aesthetics, Health and Function. It is a service that provides improvement in the appearance of 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 can 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 purposes. I have truthfully answered all of the above questions and agree to inform Dr. Freeman's office of any changes in my medical or dental history. In addition, I authorize Dr. David C. Freeman to perform a complete orthodontic evaluation.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_