## Patient Information

Patient's name ______________________________________________________ Nickname________________
Last First Middle

Address______________________________________________________________________________
Street City Zip

Home Phone______________________ Work Phone______________________ Cell Phone______________________

Email____________________________________________ School________________________________________

Birthdate______________________ Age__________ Social Security # ____________________________________

If patient is a minor, give parent's or guardian's name___________________________________________________

**Dentist**__________________________**Last Visit**_______ Physician___________________________Last Visit_______

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 ______________________

Previous Address (If less than 3 years) ______________________________________________________

Social Security #_________________________ Birthdate______________ Relationship to Patient __________________

Employer___________________________________ Occupation_____________________ No. years employed ________

Spouse's Name________________________________________________________________________

Social Security #_________________________ Birthdate______________ Relationship to Patient __________________

Employer___________________________________ Occupation_____________________ No. years employed ________

## Dental Insurance Information

Insured's Name________________________________________ Insured's Social Security #________________________
Insurance Company_______________________________ Group #_______________ ID # ______________________
Insurance Co. Address_________________________________________________ Phone # ______________________
Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name________________________________________ Insured's Social Security #________________________
Insurance Company_______________________________ Group #_______________ ID # ______________________
Insurance Co. Address_________________________________________________ Phone # ______________________

Emergency Contact Name ___________________________________________Phone___________________________

I understand that where appropriate, credit bureau reports may be obtained.
Signature (Parent's signature if minor) ________________________________________________________
Updates (date & initial) _____________________________________________________________________

**MEDICAL HISTORY**

Address ____________________________________________________ Phone _______________________________________

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _______________________________________________________

Yes No Are you allergic to any medication? ____________________________________________________

Yes No Do you have an allergy to latex or any metals? ____________________________________________

Yes No Have you had any major operations? ___________________________________________________

Yes No Have you ever been involved in a serious accident? ________________________________________

Yes No Do you have a history of a major illness? _______________________________________________

Yes No Have you ever taken any medication for bone loss, such as Fosamax or Boniva?_______________________

Yes No Do you need to premedicate for any dental or medical procedures? _______________________________

**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/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?** ( i.e. physical or mental disabilities)_______________________________________________________________________________

**DENTAL HISTORY**

What concerns you most about your teeth? __________________________________________________________

Yes No Are you presently in any dental pain? _____________________________________________

Yes No Have you ever experienced any unfavorable reaction to dentistry? _________________________

Yes No Have you 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 or pressure? ___________________________

Yes No Do your gums bleed when you brush? _______________________________________________

Yes No Do you have any type of thumb or tongue habit? ______________________________________

Yes No Are you a mouth breather? _______________________________________________________

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning?________________

Yes No Are you aware of your jaw clicking or popping? _______________________________________

Yes No Are you aware of clenching your teeth? ____________________________________________

Yes No Have you ever been told that you grind your teeth? ____________________________________

Yes No Do you have "tension" headaches?_________________________________________________

Yes No Have you ever experienced chronic ringing in your ears?_______________________________

Yes No Have you ever seen an orthodontist? If yes, who and when?_____________________________

Yes No What is your attitude toward receiving orthodontic treatment? __________________________

Yes No Has anyone in your family received orthodontic treatment? ____________________________

How did they feel about the result?_________________________________________________

What is your attitude toward receiving orthodontic treatment? __________________________

Yes No Is the patient is under age 16? If yes, what is the height of biological parents? Mom________ Dad________

Yes No Are you aware that some appointments will be during school/work hours? ______________________

**For FEMALE Patients only:**

Yes No Are you pregnant?

Yes No Has menstruation started? If yes, approximately how long ago? _______________________

Please list some hobbies or interests _____________________________________________________________

**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, especially if retainers are not worn as directed. I have read and understand this paragraph. 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. Hirsh and his staff to perform a complete orthodontic evaluation.

Signature: _____________________________________________________ Date: ____________________________