PATIENT INFORMATION

Date_____

Patient'sName_____
Last First Middle

Address_____
Street City Zip

Birthdate_____ **Email address** _____

Cell Phone_____ Home Phone _____

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

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

RESPONSIBLE PARTY INFORMATION

Name_____
Last First Middle

Address_____
Street City Zip

Social Security #_____Birthdate_____

Relationship to Patient_____Employer_____

*Spouse's Name*_____

Social Security #_____Birthdate_____

Relationship to Patient_____Employer_____

DENTAL INSURANCE INFORMATION

Insurance Company_____ Phone No. _____

Policy Holder's Name_____ Birthdate _____

Social Security # _____ Insurance ID #_____

Do you have dual coverage? Yes_____ No_____ If yes:

Insurance Company_____ Phone No. _____

Policy Holder's Name_____ Birthdate _____

Social Security # _____ Insurance ID #_____

EMERGENCY INFORMATION

Name of nearest relative not living with you_____

Address_____
Street City Zip

Cell Phone_____ Home Phone _____

MEDICAL HISTORY

Physician_____ Date of Last Visit_____

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 a history of a major illness? _____

Yes No Have you had any operations? _____

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

Yes No Do you have a congenital heart defect or heart murmur? **If Yes, Do you have to be premeditated before treatment?**

Yes No Are you allergic to Latex?

Yes No Are you pregnant?

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 Nervous Disorders Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of?_____

DENTAL HISTORY

General Dentist Name_____ Phone Number_____

Address _____ Date of last visit_____

What concerns you most about your teeth?_____

Yes No Are you presently in any dental pain? _____

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 during the day?

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

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

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. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. 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. Ronald Yarbrough to perform a complete orthodontic evaluation.

Signature: _____ Date_____