

Patient Information

Date _____

Patient's Name _____ Soc. Sec. # _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Age _____ Sex _____

Patient Work Phone _____ If a minor, give parent or guardian's name _____

E-mail _____ Physician _____

General Dentist _____ Whom may we thank for referring you? _____

Reason for Consultation _____

Have you ever been examined by an orthodontist? _____ If yes, when? _____ Had Braces? _____

Siblings' name and age _____

Medical Information

Is patient in good health? Yes _____ No _____

Does patient have any history of major illness? Yes _____ No _____

Has patient enver been under the care of a physican for illness? Yes _____ No _____

If yes, give reason _____

Check any of the following for which the patient has been treated or diagnosed with:

Heart Complications . . . Emphysema Venereal Disease Psychiatric/Psychological Care...

High Blood Pressure . . . Tuberculosis. A.I.D.S. Pneumonia.....

Low Blood Pressure . . . Asthma H.I.V Positive Bone Disorders.....

Rheumatic Fever Latex Sensitivity. Blood Transfusion Herpes/Cold Sores.....

Arthritis/Rheumatism . . Allergies. Hemophilia/Prolonged Bleeding. Anemia.....

Kidney Complications . . Sinus Trouble. Neurological Disorders. Periodontal Disease.....

Ulcers Cancer Epilepsy or Seizures Endocrine Problems.....

Diabetes. Hepatitis A (Infectious) . . Fainting or Dizzy Spells Liver Involvement.....

Thyroid Problems Hepatitis B (Serum). Nervous/Anxious Hypoglycemia.....

If child, have you reached puberty? Girls - have you started menstruation? _____ Boys-has your voice changed? _____

Does patient have a tendency to colds? YES NO Sore Throats? YES NO Ear Infections? YES NO

Have tonsils and/or adenoids been removed? YES NO At what age? _____

List any drugs or medications now being taken and give reasons _____

List any allergies or drug sensitivity _____

Dental History

Have you had any injuries to the face, mouth or teeth?..... YES NO

Habits

Thumb or Finger Sucking YES NO

Mouth Breathing YES NO

Nail/Lip Biting..... YES NO

Grinding or Clenching of Teeth..... YES NO

Have you been informed of any missing or extra permanent teeth?..... YES NO

Are you aware that some appointments will be during school/work hours? YES NO

Financially Responsible Party Information

Ms. Miss Married Separated
Name Mrs. Mr. Dr. _____ Single Divorced
Last First Middle
Residence _____
Street City State Zip
Mailing Address _____
How Long at this address _____ Home Phone _____ Work Phone _____
Previous Address _____
Street City State Zip
Social Security # _____ Birthdate _____ Relationship to Patient _____
Employer _____ Occupation _____ No. Years Employed _____
Spouse's Name _____ Relationship to Patient _____
Employer _____ Occupation _____ No. Years Employed _____
Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Do you have orthodontic coverage? Yes No Benefit amount: _____ If no, please skip this section.
Insured's Name _____ Insured's Soc. Sec. # & DOB _____
Insured's Employer _____ Group No. _____ Member ID _____
Insured's Employer Address _____
Insurance Company Name & Address _____
Insurance Company Phone Number _____
Secondary Insurance? Yes No Benefit amount: _____ If no, please skip this section.
Insured's Name _____ Insured's Soc. Sec. # & DOB _____
Insured's Employer _____ Group No. _____ Member ID _____
Insured's Employer Address _____
Insurance Company Name & Address _____
Insurance Company Phone Number _____

Emergency Information

Name of nearest relative not living with you _____
Complete Address _____
Phone _____

Authorization and Release

I authorize the dentist to release any information including the diagnosis and records for treatment rendered to me or my child if necessary for insurance purposes. I also authorize direct payment of insurance benefits to the dentist for services rendered when indicated.
I hereby authorize Care Credit, on behalf of Gerald A. Smith, DMD to obtain a copy of my credit report from a credit reporting agency for the purpose of considering payment options.

Responsible Party Signature _____
Spouse Signature _____