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Today's date_____

Patient's Name _____

___Male ___ Female Age____ Birth date _____

Address _____

For Minor

Parent(s) are: ___Married ___Divorced ___Separated ___Single __Other_____

Patient lives with: __Mother __Father __Both __Other_____

Mother/Guardian's name_____ Father/Guardian's name _____

Address/ Phone (if not above)_____ Address /Phone (if not above)_____

_____ _____

Cell Phone:_____

Patient

E-mail Address_____

Responsible Party if different than (minor)

E-Mail Address_____

When is the best time & phone number to reach you regarding orthodontic needs?_____

MEDICAL INFORMATION *Have you ever had or been treated for*:

Heart condition (heart murmur, heart attack, pacemaker)	yes no	Rheumatic fever	yes no
Jaundice	yes no	Diabetes	yes no
Asthma	yes no	Abnormal blood pressure	yes no
Hay fever/Allergies	yes no	Ulcers	yes no
Hepatitis	yes no	Tuberculosis or lung disease	yes no
Arthritis	yes no	Abnormal coughing	yes no
Stroke	yes no	Epilepsy	yes no
AIDS or HIV positive infection	yes no	Anemia	yes no
Emotional disturbance	yes no	Venereal disease	yes no
Accident to head / face / teeth	yes no	Prolonged bleeding	yes no
ADD/ADHD	yes no	Herpes/cold sores	yes no
Learning / Behavior Disability	yes no	Hospital/Outpatient Surgery	yes no
Explanation: _____		Date_____ Reason_____	
		Dental Anxiety	yes no
		Explanation: _____	

The following questions should be answered about the patient being examined.

1. Are you in good health? _____
2. Are you allergic to any food or medication? If so, what? _____
3. Are you taking any medication now? If so, what?_____
4. Did you ever suck your thumb or fingers? If so, have you stopped? At what age? _____
5. Do you have any problems normally breathing through your nose (or have any sinus/tonsil problems)? If so, what?_____
6. Have you ever seen an orthodontist before, If so when?_____
7. (Females) Are you pregnant? _____
8. (Females-Adolescent) Has menarche (menstrual period) begun? Yes No N/A

- Family dentist name _____
- When was your **last dental check up** *(circle)*? Winter Spring Summer Fall Year: 20_____
- How did you hear about us (Please check all that apply)? □Dentist □Mailer □ Phone Book □ Insurance □ Driving By □ Invisalign □Friend/family (please list)_____
- Physician's Name_____
- School_____ Grade_____

So that we may better understand *your* needs, please tell us the main reason(s) that you and/or your child are having an orthodontic evaluation (check all that apply)??

□ Overbite □ Crowding/Crooked teeth □ Spacing □ Underbite □ Dentist referred me

□ Not Sure □ Other_____

SIBLING PROGRAM:

The American Association of Orthodontists recommends that children receive an orthodontic evaluation by age 7. Please give us the names of other siblings in the family, so that we may remind you of the most appropriate time for a complimentary exam.

Name _____ Date of Birth _____ Age_____

Name _____ Date of Birth _____ Age_____

Name _____ Date of Birth _____ Age_____

_____

Patient/parent's Signature Date

Thank you for giving us the opportunity to serve you. Dr. Weinberg and the Prairie Orthodontics Staff

□□ Dr. Reviewed_____

□□ Staff Reviewed_____

Date _____ **Confidential Responsible Party Information** A B C

Name_____ Marital Status_____
Last First Middle

Residence_____
Street City State Zip

Mailing Address_____
Street City State Zip

How long at this address_____ Do you : Own_____ Rent_____ Other_____

Home Phone_____ Work Phone_____ Cell Phone_____

Previous Address (if less than 3 yrs.)_____
Street City State Zip

Social Security #_____ Birth date_____ Relationship to Patient_____

Employer_____ Occupation_____ No. Years Employed_____

Spouse's Name_____ Relationship to Patient_____
Last First Middle

Employer_____ Occupation_____ No. Years Employed_____

Social Security #_____ Birth date_____ Work Phone_____

Confidential Patient Information

Patient's Name_____
Last First Middle

Address_____
Street City State Zip

Home Phone_____ Birth date_____ Social Security #_____

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

Insurance Information

Policy Holder's Name_____ and Soc.Sec. #_____

Insurance Company_____ Group No._____ Union Local No._____

Insurance Co. Address_____ Insurance Co. Phone_____

Policy Holder's Employer_____ ID # _____

Do you have dual coverage? No s Yes s If yes:

Policy Holder's Name_____ and Soc.Sec. #_____

Insurance Company_____ Group No._____ Union Local No._____

Insurance Co. Address_____ Insurance Co. Phone_____

Policy Holder's Employer_____ ID #_____

Emergency Information

Name of nearest relative not living with you_____Phone_____

Relationship_____Complete Address_____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor)_____

Updates (date & initial)_____