New Patient Information Forms

Date_____

Patient's name _____ Nickname_____
Last First Middle

Birthdate_____ Social Security # _____ Email_____ _____

Address _____
Street Apt# City Zip

School_____ Sports/Hobbies _____

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

RESPONSIBLE PARTY INFORMATION

Parent/Guderian Name _____
Last First Middle

Social Security #_____ Birthdate_____ Relationship to Patient _____

Mailing Address_____
Street Apt# City Zip

Martial Status(Please Circle One) **Single** **Married** **Divorced** **Widowed** **Separated**

Home phone_____ Work phone_____

Cell phone_____ Carrier: _____ would you like to receive text messages? Yes / No

Email_____ @_____. com

Spouse's Name_____ Relationship to Patient _____

Social Security #_____Birthdate_____Cell Phone _____ Carrier:_____

DENTAL INSURANCE INFORMATION

Insured's Name_____ Insured's Social Security # _____

Insurance Company Name _____ Insurance Phone No._____

Insured's Member ID No._____ Group/Employer Name_____

Insurance Co. Address_____

EMERGENCY INFORMATION

Name of nearest relative not living with you name _____

Phone No._____ Relation to Patient_____ ___

TOP SMILE
ORTHODONTICS

MEDICAL HISTORY

Physician _____ Date of Last Visit _____

Address _____ Phone _____

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

Yes No Is the patient taking any medication? _____
Yes No Is the patient allergic to any medication? _____
Yes No History of a major illness? _____
Yes No Has the patient had any operations? _____
Yes No Ever been involved in a serious accident? _____
Yes No Have seen a physician in the last 12 months? Why? _____
Yes No Is the patient pregnant? _____

Circle any of the medical conditions below that the patient has had or currently has.

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? _____

DENTAL HISTORY

General Dentist Name _____ Phone No. _____

Date of last visit _____

What concerns you most about your teeth? _____

Yes No Is the patient presently in any dental pain? _____
Yes No Ever experienced any unfavorable reaction to dentistry? _____
Yes No Has the patient 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? Where? _____
Yes No Is any part of your mouth sensitive to pressure? Where? _____
Yes No Do gums bleed when brushing? _____
Yes No Any type of thumb or tongue habit? _____
Yes No Is the patient a mouth breather? _____
Yes No Has the patient ever seen an orthodontist? If yes, who and when? _____
Yes No What is the patient's attitude toward receiving orthodontic treatment? _____
Yes No Has anyone in the family received orthodontic treatment? _____
How did they feel about the result? _____
Yes No Do teeth or jaws ever feel uncomfortable first thing in the morning? _____
Yes No Experience jaw clicking or popping? _____
Yes No Aware of clenching or grinding teeth during the day? _____
Yes No Experience "tension" headaches? _____
Yes No Has the patient ever experienced chronic ringing in the ears? _____
Yes No Does the patient need extra help with instructions? _____
Yes No Is the patient sensitive or self-conscious about his/her teeth? _____
Yes No Are you aware that some appointments will be during school hours? _____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been answered accurately. I understand that providing false or incorrect information can be dangerous to my health.

Patient/Parent/Guardian Signature _____ **Date:** _____