

Responsible Party Information

Name	_____	_____	_____	Marital Status	_____
	Last	First	Middle		
Residence	_____	_____	_____	_____	_____
	Street	City	State	Zip	
Mailing Address	_____	_____	_____	_____	_____
	Street	City	State	Zip	
			E-Mail Address	_____	
How long at this address	_____	Home Phone:	_____	Work:	_____
				Cell:	_____
Previous Address (if less than 3 yrs.)	_____	_____	_____	_____	_____
	Street	City	State	Zip	
Social Security #	_____	Birthdate	_____	Relationship to Patient	_____
Employer	_____	Occupation	_____	No. Years Employed	_____
Spouse's Name	_____	_____	_____	Relationship to Patient	_____
	Last	First	Middle		
Employer	_____	Occupation	_____	No. Years Employed	_____
Social Security #	_____	Birthdate	_____	Work Phone	_____

CONFIDENTIAL

Patient Information

Patient's Name	_____	_____	_____		
	Last	First	Middle		
Address	_____	_____	_____	_____	_____
	Street	City	State	Zip	
Home Phone	_____	Birthdate	_____	Social Security #	_____
If patient is a minor, give parent's or guardian's name	_____				
Whom may we thank for referring you to our office?	_____				

Dental Insurance Information

Policy Holder's Name	_____	Social Security #	_____
Policy Holder's Address (if different from patient)	_____		
	Relationship to patient	_____	
Policy Holder's Phone #	_____	Policy Holder's Employer	_____
Insurance Company	_____	Group #	_____
Insurance Company Phone #	_____		
Do you have dual coverage?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes: _____
Policy Holder's Name	_____	Social Security #	_____
Policy Holder's Address	_____		
Policy Holder's Phone #	_____	Policy Holder's Employer	_____
Insurance Company	_____	Group #	_____
Insurance Phone #	_____		

Emergency Information

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

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

A B C

Signature (Parent's signature if minor) _____ Date _____

Updates (date & initial) _____

Confidential (for record and pretreatment evaluation)

Pond Orthodontics

MEDICAL HISTORY

Physician _____ Phone _____ City _____

Yes No

- Does patient breathe through mouth at night?
- Does patient breathe through mouth constantly?
- History of allergies effecting breathing or asthma?
- Are tonsils or adenoids removed? (which) _____
- Other surgeries? (list) _____
- Does patient have complaints related to the jaw joints? If yes, please check related problems:
Pain L R Both Noise L R Both Headaches L R Both Locking L R Both Soreness in the jaw muscles L R Both
- Does patient have arthritis anywhere in their body? (where) _____
- Does patient have a heart murmur or history of rheumatic fever?
- Is an antibiotic recommended by the patient's physician before certain dental procedures due to a heart condition or rheumatic fever?
What antibiotic is prescribed and which pharmacy do you use? _____

- Cankers or cold sores? (which) _____
- Is patient currently taking medications? If so, which ones? _____
- Is patient allergic to any medications? If so, which ones? _____
- Has patient reached puberty? _____

Habits:

- Does patient smoke?
- Does patient suck finger or thumb? If yes, how often, how long and how forcefully? _____
- Does patient clench teeth?

Circle any of the following problems that the patient received treatment for:

Hepatitis	Fainting	Arthritis	Asthma
Bleeding Problems	Emotional	Nervous Disorders	Rheumatic Fever
Seizures	Eating Disorders	Hormone Problems	Tuberculosis
AIDS	Diabetes		

DENTAL HISTORY

Dentist _____ Phone _____ City _____

Date of last dental cleaning _____

What is the most important aspect of the patient's tooth or jaw alignment that you would like us to fix? _____

- Has the patient had prior orthodontic treatment? If so, what did it accomplish and what device was used? _____
- Has the patient consulted with another orthodontist? If so, Dr. _____ in (City, State) _____
- Has anyone in patient's family been treated at our office? (whom) _____
- Have any permanent teeth or the jaws been injured? (which) _____
- Problems pronouncing sounds? (which) _____
- Impacted or missing teeth? (which) _____
- Gum problems? (what) _____
- High rate of dental decay (cavities)?
- Does patient play a musical instrument with their mouth? (which) _____
- What sports does patient participate in? (which) _____

Signature of parent or responsible party filling out this page: _____ Date _____