PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Date_____

Patient's name_____
Last First Middle

Address_____
Street City Zip

Nickname_____ Birthdate_____ Social Security #_____

School_____ Sports/Hobbies_____

Parent or guardian name_____

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

RESPONSIBLE PARTY INFORMATION

Name_____
Last First Middle

Mailing Address_____
Street City Zip

Home phone_____ Work phone_____ Cell phone_____

Email address_____

Social Security #_____ Birthdate_____ Relationship to Patient_____

Employer_____

Spouse's Name_____ Relationship to Patient_____

Employer_____ Occupation_____

Social Security #_____Birthdate_____Cell Phone_____

DENTAL INSURANCE INFORMATION

Insured's Name_____ Insured's Social Security #_____

Insured's Birthdate:_____

Insurance Company_____ Group No._____ Local No._____

Insurance Co. Address_____ Phone No._____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_____ Insured's Social Security #_____

Insurance Company_____ Group No._____ Local No._____

Insurance Co. Address_____ Phone No._____

EMERGENCY INFORMATION

Name of nearest relative not living with you_____ Phone_____

MEDICAL HISTORY

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

Yes No Is the patient taking any medication? _____
Yes No Does the patient have any allergies? _____
Yes No History of a major illness? _____
Female Patients only:
Yes No Has menstruation started?
Yes No Is the patient pregnant?

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

Bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	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_____Date of last visit _____

What concerns you most about your teeth?_____

_____

Yes No Is the patient presently in any dental pain? _____
Yes No Have there been any injuries to face, mouth, or teeth? _____
Yes No Is any part of patient's mouth sensitive to temperature? Where? _____
Yes No Is any part of patient's mouth sensitive to pressure? Where? _____
Yes No Any type of thumb or tongue habit? _____
Yes No Has the patient ever seen an orthodontist? If yes, who and when? _____
Yes No Good attitude toward receiving orthodontic treatment?_____
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 Has the patient ever experienced chronic ringing in the ears? _____
Yes No Is the patient sensitive or self-conscious about his/her teeth? _____

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. Kunsemiller to perform a complete orthodontic evaluation.

Signature: _____ Date: _____