## PATIENT INFORMATION

NAME _____ MARITAL STATUS _____

ADDRESS _____
STREET CITY STATE ZIP

HOME PHONE _____ BIRTHDATE _____ SOC. SEC. No. _____

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

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

## RESPONSIBLE PARTY INFORMATION

NAME _____ MARITAL STATUS _____
LAST FIRST MIDDLE

RESIDENCE _____
STREET CITY STATE ZIP

MAILING ADDRESS _____
STREET CITY STATE ZIP

HOW LONG AT THIS ADDRESS _____ HOME PHONE _____ WORK PHONE _____

PREVIOUS ADDRESS (If less than 3 years) _____

SOC. SEC. No. _____ BIRTHDATE _____ RELATIONSHIP TO PATIENT _____

EMPLOYER _____ OCCUPATION _____ No. OF YEARS _____

SPOUSE'S NAME _____ RELATIONSHIP TO PATIENT _____
LAST FIRST MIDDLE

EMPLOYER _____ OCCUPATION _____ No. OF YEARS _____

SOC. SEC. No. _____ BIRTHDATE _____ WORK PHONE _____

## INSURANCE INFORMATION

INSURED NAME _____ INSURED SOC. SEC. No. _____

INSURANCE COMPANY _____ GROUP No. _____ LOCAL No. _____

INSURANCE CO. ADDRESS _____

DO YOU HAVE DUAL COVERAGE ? YES _____ NO _____ IF YES:

INSURED'S NAME _____ INSURED'S SOC. SEC. No. _____

INSURANCE CO. ADDRESS _____

INSURED'S EMPLOYER _____

## EMERGENCY INFORMATION

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU _____

COMPLETE ADDRESS _____

PHONE _____

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

Signature (parent's signature, if minor) _____

Updates (date & initial) _____ _____ _____ _____ _____

## PATIENT'S DENTAL HISTORY

SEX _____ AGE _____ BIRTHDATE _____ HEIGHT _____ WEIGHT _____

HAVE YOU HAD UNFAVORABLE REACTION (ALLERGY) TO MEDICATION ? NO ____ YES _____

HAVE YOU HAD ANY UNFAVORABLE REACTION TO DENTAL CARE ? _____

REASON FOR CONSULTATION _____

DOES PATIENT DESIRE ORTHODONTIC TREATMENT ? _____ ACCIDENTS TO MOUTH OR TEETH ? _____

ORAL HABITS: FINGER SUCKING, ETC. _____ NAIL BITING ? _____ MOUTH BREATHING ? _____ LIP OR TONGUE BITING ? _____

VOICE: SPEECH _____ STAMMER _____ LISP _____ PRESENT HEALTH: EXCELLENT _____ GOOD _____ FAIR _____ POOR _____

PATIENT'S DENTIST _____ PATIENT'S PHYSICIAN _____

CHILDREN/SIBLING(S) NAMES & DATES OF BIRTH _____

_____

_____

OVER