Date_____ **Confidential Responsible Party Information** A B C

Name_____ Marital Status_____
Last First Middle

Residence_____ ☐ Own ☐ Rent
Street City State Zip

Mailing Address_____ Email_____
Street City State Zip

How long at this address_____ Previous Address_____
(if less than 3 yrs) Street City State Zip

Home Phone_____ Work Phone_____ Cell Phone_____

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?_____

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_____

Do you have dual coverage? No ☐ Yes ☐ 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_____

Emergency Information

Name of nearest relative not living with you_____

Complete Address_____

Phone_____ Relationship:_____

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MEDICAL HISTORY — Has patient ever had any of the following: (Please Check)

☐ Heart problem	☐ Glaucoma	☐ Respiratory problem	☐ Kidney problem
☐ Rheumatic fever	☐ Hepatitis	☐ Thyroid problem	☐ Allergies
☐ Epilepsy (seizure)	☐ Prolonged bleeding	☐ Arthritis	☐ Diabetes
☐ Major operation	Other _____		

Is patient presently under the care of a physican? _____ If so, for what? _____

List all drugs or medicines to which patient has had a reaction (allergy) _____

DENTAL HISTORY — Has patient ever experienced any of the following: (Please Check)

☐ Sensitive teeth	☐ Root canal	☐ Cleft lip/palate	☐ Periodontal disease
☐ Thumb sucking beyond age 4	☐ Tongue thrust	☐ Severe blow to teeth/jaws	☐ Bleeding gums
☐ Clicking/popping in jaw joint	☐ Fractured teeth	☐ Extraction of permanent teeth	☐ Mouth breathing

Was your dentist going to send x-rays to us for this appointment?	Y	N
Is patient on regular 6 month or yearly recall schedule with family dentist?	Y	N
Has patient previously seen an orthodontist?	Y	N
Has any other member of the family undergone orthodontic treatment?	Y	N
Were you aware that an orthodontic problem might exist before being referred to our office?	Y	N

Patient's main interests and activities (hobbies, sports, music, ect.) _____

_____

_____

_____

_____

By signing this form, you will consent to out use and disclosure of your protected health information to communicate with your other healthcare providers and issuance company, carry out treatment, payment activities, and healthcare operations. I understand that where appropriate, credit bureau reports will be obtained.

Signature (Parent's signature minor)_____

Updates (date & initial)_____