

WELCOME TO OUR OFFICE!		PATIENT INFORMATION						
Date								
Patient's Name					Birth Date)		
Address	Last	First		Middle Initial				
Home Phone	Street	Cell Phone	City			Zip		
Patient:Responsible Party:								
Sibling Information	Email Address		- '		Email Address			
Name		Birth date	Name _		B	irth date _		
Name		Birth date	Name _		B	irth date _		
RESPONSIBLE PARTY INFORMATION								
Name								
Residence	Last		First		Middle		Aarital Status	
Residence Mailing Address	Street		City		State	Zip		
How long at this address	Street	Home/Cell Ph	City one		State k Phone	Zip		
Previous Address (if les		s)						
Social Security #		Street	City		State Patient	Zip		
Employer				· ·				
Spouse's Name		First		Relation	ship to Pati	ent		
Spouse's Employer			Occupation		No. Years	Employed	dt	
Spouse's Social Securi	Spouse's Social Security #Spouse's Birth Date							
DENTAL INSURANCE INFORMATION								
Insured's Name			DOB	Member ID or S	SN #			
Insurance Company				Group #	Ph	one #		
Insurance Co. Address								
Do vou have dual cove	rage? Yes □	No □ If Yes. p	lease continue:					
Do you have dual coverage? Yes Do Do If Yes, please continue:								
Insurance Company Insurance Co. Address				Group #	Ph	one #		
		EMERGE	NCY INFORMA	TION				
Name of nearest relative not living with you								
Complete Address Relationship to Patient								
Signature (Parent's signat	ture, if minor)				Date			
Signature (Parent's signature, if minor) Date								
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Why are you or your child seeking orthodontic treatment? (Please be as specific as possible):							
Who may we thank for referring you to our office?							
DENTAL HISTORY General Dentist:	Phone: ()						
Address:							
Date of last dental examination:							
MEDICAL HISTORY							
Family Physician:	Phone ()						
Address:							
Is the patient currently under a physician's care? Yes No							
If yes, please explain							
Is the patient taking any medicine at this time? Yes No							
If yes, please list							
Is the patient allergic to any medications? Yes No If yes, please list							
Does the patient have any other allergies? Yes No If yes, please list							
Does the patient need to be premedicated (with antibiotics) for routine dental procedures? Yes No							
If yes, please specify and give reason for this need:							
Has the patient ever been hospitalized? Yes No If yes, please explain							
Females: Is the patient pregnant? Yes No							
Does the patient have or has the patient ever had any of the following?							
Yes No Yes No	Yes No						
□ □ AIDS/HIV+ □ □ Cold Sores	□ □ Injury to head						
□ □ Anemia □ □ Rheumatic Fever	□ □ Kidney Disease						
□ □ Arthritis □ □ Diabetes □ □ Asthma □ □ Epilepsy/Seizures	□ □ Lung Disease □ □ Previous Surgery						
□ □ Oral Ulcers □ □ Hearing Problem	□ □ Psychological Therapy						
□ □ Birth Defects □ □ Heart Condition	□ □ Radiation or cancer therapy						
□ □ Bleeding Disorder □ □ Speech Therapy	□ □ Tonsils/Adenoid Surgery						
□ □ Cerebral Palsy □ □ Hepatitis	□ □ Injury to face/teeth/gums						
Does the patient have any disease, condition, or problem not listed above? Please explain:							
DOES/DID THE PATIENT:							
Grind his/her teeth at night? Yes No Brush his/her teeth Docasionally Reluctantly							
Suck thumb, finger, pacifier? Yes No If yes, what age was the habit discontinued?							
GROWTH STATUS:							
Height: Weight:							
Females: Has the patient started her menstruation? Yes No If yes, what age?							
Males: Has the patient yet undergone voice changes? Yes No Facial hair growth? Yes No							
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Signature of the person completing this form:							
Relationship to the patient:Today's Date:							
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