Date: _____

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: _____

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

Confidential Responsible Party Information

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 then 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: _____

Insurance Information

Policy Holder's Name: _____ Social Security #: _____

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: _____ Social Security #: _____

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: _____
Street City State Zip

Phone: _____ Relationship:_____

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

Signature (Parent's Signature if minor) _____

Updates (date & initial) _____

CONFIDENTIAL (for record and pretreatment evaluation)

Patients Name: _____

Medical History

Physician: _____ Date of Last Visit: _____

Address: _____ Phone Number: _____

Please check YES or NO (If YES, please fill in details)

YES	NO	
☐	☐	Are you taking any medication? _____
☐	☐	Are you allergic to any medication? _____
☐	☐	Do you have a history of a major illness? _____
☐	☐	Have you had any major operations? _____
☐	☐	Have you ever been involved in a serious accident? _____
☐	☐	Have you ever taken a bisphosphonate medication (i.e. Fosamax, etc.)? _____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	☐	Congenital Heart Defect	☐	☐ Heart Murmur		Nervous Disorders	☐
ADHD	☐	Diabetes	☐	☐ Hepatitis/Liver Problems		Pneumonia	☐
Anemia	☐	Dizziness	☐	☐ Herpes		Prolonged Bleeding	☐
Arthritis	☐	Epilepsy	☐	☐ High Blood Pressure		Radiation/Chemotherapy	☐
Asthma or Hay Fever	☐	Gastrointestinal Disorders	☐	☐ HIV/AIDS		Rheumatic Fever	☐
Autism	☐	Emotional Disorders	☐	☐ Kidney Problems		Tuberculosis	☐
Bone Disorders	☐	Heart Problems	☐	☐ Learning Difficulties		Tumor Or Cancer	☐

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

_____

Dental History

Dentist: _____ Date of last visit: _____

What concerns you most about your teeth? _____

Patients Height: _____ Weight: _____ Father's Height: _____ Mother's Height: _____

Please check YES or NO (If YES, please fill in details)

YES	NO	
☐	☐	Are you presently in any dental pain? _____
☐	☐	Have you ever experienced any unfavorable reaction to dentistry? _____
☐	☐	Have you ever lost or chipped any teeth? _____
☐	☐	Have there been any injuries to face, mouth, or teeth? _____
☐	☐	Is any part of your mouth sensitive to temperature or pressure? _____
☐	☐	Do your gums bleed when you brush? _____
☐	☐	Do you have any type of thumb or tongue habits? _____
☐	☐	Are you a mouth breather? _____
☐	☐	Have you ever seen an orthodontist? If yes, who and when? _____
☐	☐	Has anyone in your family received orthodontic treatment? _____
☐	☐	Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
☐	☐	Are you aware of your jaw clicking or popping? _____
☐	☐	Are you aware of clenching your teeth during the day? _____
☐	☐	Have you ever been told that you grind your teeth? _____
☐	☐	Do you have "tension" headaches? _____
☐	☐	Are you aware that some appointments will be during school/work hours? _____

Please list your hobbies or interests: _____

What concerns do you have about orthodontic treatment? _____

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. Conmy to perform a complete orthodontic evaluation

Signature: _____ Date: _____

(Parent or Guardian if patient is a minor) Update: _____

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