

## Patient Information

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Soc. Sec.# \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Patient Work Phone \_\_\_\_\_ If a minor, give parent or guardian's name \_\_\_\_\_

E-mail \_\_\_\_\_ Physician \_\_\_\_\_

General Dentist \_\_\_\_\_ Whom may we thank for referring you? \_\_\_\_\_

Reason for Consultation \_\_\_\_\_

Have you ever been examined by an orthodontist? \_\_\_\_\_ If yes, when? \_\_\_\_\_ Had Braces? \_\_\_\_\_

Siblings' name and age \_\_\_\_\_

## Medical Information

Is patient in good health? ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Does patient have any history of major illness? ..... Yes \_\_\_\_\_ No \_\_\_\_\_

Has patient ever been under the care of a physician for illness? ..... Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, give reason \_\_\_\_\_

Check any of the following for which the patient has been treated or diagnosed with:

- |                        |                          |                          |                          |                               |                          |                                |                          |
|------------------------|--------------------------|--------------------------|--------------------------|-------------------------------|--------------------------|--------------------------------|--------------------------|
| Heart Complications    | <input type="checkbox"/> | Emphysema                | <input type="checkbox"/> | Venereal Disease              | <input type="checkbox"/> | Psychiatric/Psychological Care | <input type="checkbox"/> |
| High Blood Pressure    | <input type="checkbox"/> | Tuberculosis             | <input type="checkbox"/> | A.I.D.S.                      | <input type="checkbox"/> | Pneumonia                      | <input type="checkbox"/> |
| Low Blood Pressure     | <input type="checkbox"/> | Asthma                   | <input type="checkbox"/> | H.I.V. Positive               | <input type="checkbox"/> | Bone Disorders                 | <input type="checkbox"/> |
| Rheumatic Fever        | <input type="checkbox"/> | Latex Sensitivity        | <input type="checkbox"/> | Blood Transfusion             | <input type="checkbox"/> | Herpes/Cold Sores              | <input type="checkbox"/> |
| Arthritis / Rheumatism | <input type="checkbox"/> | Allergies                | <input type="checkbox"/> | Hemophilia/Prolonged Bleeding | <input type="checkbox"/> | Anemia                         | <input type="checkbox"/> |
| Kidney Complications   | <input type="checkbox"/> | Sinus Trouble            | <input type="checkbox"/> | Neurological Disorders        | <input type="checkbox"/> | Periodontal Disease            | <input type="checkbox"/> |
| Ulcers                 | <input type="checkbox"/> | Cancer                   | <input type="checkbox"/> | Epilepsy or Seizures          | <input type="checkbox"/> | Endocrine Problems             | <input type="checkbox"/> |
| Diabetes               | <input type="checkbox"/> | Hepatitis A (Infectious) | <input type="checkbox"/> | Fainting or Dizzy Spells      | <input type="checkbox"/> | Liver Involvement              | <input type="checkbox"/> |
| Thyroid Problems       | <input type="checkbox"/> | Hepatitis B (Serum)      | <input type="checkbox"/> | Nervous/Anxious               | <input type="checkbox"/> | Hypoglycemia                   | <input type="checkbox"/> |

If child, have you reached puberty? Girls - have you started menstruation? \_\_\_\_\_ Boys - has your voice changed? \_\_\_\_\_

Does patient have a tendency to colds?  YES  NO Sore Throats?  YES  NO Ear Infections?  YES  NO

Have tonsils and/or adenoids been removed?  YES  NO At what age? \_\_\_\_\_

List any drugs or medications now being taken and give reasons \_\_\_\_\_

List any allergies or drug sensitivity \_\_\_\_\_

## Dental History

Have you had any injuries to the face, mouth or teeth? .....  YES  NO

Habits Thumb or Finger Sucking .....  YES  NO

Mouth Breathing .....  YES  NO

Nail/Lip Biting .....  YES  NO

Grinding or Clenching of Teeth .....  YES  NO

Have you been informed of any missing or extra permanent teeth? .....  YES  NO

Are you aware that some appointments will be during school/work hours? .....  YES  NO

## Financially Responsible Party Information

Ms.  Miss  Married  Separated  
Name  Mrs.  Mr.  Dr. \_\_\_\_\_  Single  Divorced  
Last First Middle

Residence \_\_\_\_\_  
Street City State Zip

Mailing Address \_\_\_\_\_

How Long at this address \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Previous Address (if less than 3 years) \_\_\_\_\_  
Street City State Zip

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Work Phone \_\_\_\_\_

## Insurance Information

Do you have orthodontic coverage?  Yes  No Benefit amount: \_\_\_\_\_ If no, please skip this section.

Insured's Name \_\_\_\_\_ Insured's Soc. Sec # \_\_\_\_\_

Insured's Employer \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

Insured's Employer Address \_\_\_\_\_

Insurance Company Name & Address \_\_\_\_\_

Insurance Company Phone Number \_\_\_\_\_

Secondary Insurance?  Yes  No Benefit amount: \_\_\_\_\_ If no, please skip this section.

Insured's Name \_\_\_\_\_ Insured's Soc. Sec. # \_\_\_\_\_

Insured's Employer \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

Insured's Employer Address \_\_\_\_\_

Insurance Company Name & Address \_\_\_\_\_

Insurance Company Phone Number \_\_\_\_\_

## Emergency Information

Name of nearest relative not living with you \_\_\_\_\_

Complete Address \_\_\_\_\_

Phone \_\_\_\_\_

## Authorization and Release

I authorize the dentist to release any information including the diagnosis and records for treatment rendered to me or my child if necessary for insurance purposes. I also authorize direct payment of insurance benefits to the dentist for services rendered when indicated. I hereby authorize OrthoBanc, LLC, on behalf of James J. Awbrey, IV, D.M.D. to obtain a copy of my credit report from a credit reporting agency for the purpose of considering payment options.

Responsible Party Signature \_\_\_\_\_

Spouse Signature \_\_\_\_\_