

Patient Information								
Name		First		Middle	Sex	Marital Status		
Address	Street	City		State		Zip		
Birthdate		,						
Home Phone								
Employer General Dentist				. rears cr	прюуец			
Who may we thank for referring you								
who may we thank for referring you	to our office							
	Spouse / Additi	onal Contact Inform	ation					
Name								
Last		First			Middle			
Address	Street	City		State		Zip		
Birthdate	E-mail		Relationship to P	atient _				
Home Phone	Cell Phone	Work Phone	999-999-9	999	_ ext			
Employer								
Insurance Information								
Policy Owner's Name		Policy Owner's Soci	al Security #					
Policy Owner's Birthdate	MM-DD-YYYY	Relationship to Pati	ent		999-99-9999			
Policy Owner's Employer		Employer's Address						
Insurance Company	Group No. (plan, local, or policy)							
Insurance Co. Address	Insurance Phone No							
		lary Insurance						
Policy Owner's Name		Policy Owner's Soc	ial Security #					
Policy Owner's Birthdate	AMA DD WWW	Relationship to Pat	ent		999-99-9999			
Policy Owner's Employer								
Insurance Company		Group No. (plan, local, or policy)						
Insurance Co. Address		Insurance Phone No						

Are you under the care of a physician? Yes No If Yes, explain		Medical History	
Are you pregnant Yes No If so how many weeks  What are the main concerns that you would like orthodontics to accomplish?  Have you ever been evaluated for orthodontic treatment? Yes No  Have you tonsils or adenoids been removed? Yes No  Do you have any missing or extra permanent teeth? Yes No  Have you ever had an injury to: (select all that apply) Teeth Mouth Chin  Do you have speech problems? Yes No if Yes, explain  Do you have speech problems? Yes No Do you smoke? Yes No Do you gums bleed? Yes No Do you smoke? Yes No Do you gums bleed? Yes No Do you smoke? Yes No Do you gums bleed? Yes No Do you smoke? Yes No Do you may for following habits?  Clenching/Grinding Teeth Mouth Breather Tongue Thrusting Thumb/ Finger Sucking  Are you allergic to any of the following?  Aspirin Erythromycin Codeine Penicillin Tetracycline Latex  Any Metals/Plastics  Other Allergies/Sensitivites:  List all drugs you are currently taking  List any serious medical condition(s) treated  Signature  List any serious medical condition(s) treated with the strictest of confidences and it is my responsibility to inform this office of any changes in my medical status.  I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office.  I understand that where appropriate, credit bureau reports may be obtained.	Are you under the care of a physician?	es No If Yes, explain	
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