

PLEASE PRINT

LAST NAME	FIRST NAME	NICKNAME	SEX	BIRTHDATE	AGE
MAILING ADDRESS		CITY, STATE, ZIP CODE		SOC. SECURITY NO.	

IN CASE WE NEED TO CONTACT YOU DURING YOUR TREATMENT, THESE PHONE NUMBERS CAN BE HELPFUL...

HOME	WORK	MOBILE	PAGER	E-MAIL ADDRESS
SCHOOL (if student)	GRADE	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVOR.	EMPLOYEED BY/ OCCUPATION	
WHO MAY WE THANK FOR YOUR REFERRAL?		YOUR GENERAL DENTIST		SIBLINGS AND AGES

PARENT INFORMATION (Please complete if patient is a minor)

FATHER'S NAME _____ ADDRESS (if different) _____ CITY _____ STATE _____ ZIP _____ HOME PHONE # _____ WK PHONE # _____ MOBILE # _____ PAGER # _____ SS # _____ EMPLOYER _____ EMPL. ADDRESS _____ EMPL. CITY _____ STATE _____ ZIP _____	MOTHER'S NAME _____ ADDRESS (if different) _____ CITY _____ STATE _____ ZIP _____ HOME PHONE # _____ WK PHONE # _____ MOBILE # _____ PAGER # _____ SS # _____ EMPLOYER _____ EMPL. ADDRESS _____ EMPL. CITY _____ STATE _____ ZIP _____
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INFORMATION ABOUT PERSON RESPONSIBLE FOR THIS ACCOUNT

NAME	RELATIONSHIP TO PATIENT	EMPLOYED BY/OCCUPATION
MAILING ADDRESS	CITY, STATE, ZIP	HM. PH. WK. PH.
IF DIVORCE IS INVOLVED, WHO IS THE CUSTODIAN?	MAY PT. INFO. BE RELEASED TO THE NONCUSTODIAL PARENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	

MEDICAL HISTORY

PLEASE CHECK IF PT. HAS OR HAS HAD...
(Y) (N) (Y) (N)

<input type="checkbox"/> (<input type="checkbox"/>) JOINT SWELLING	<input type="checkbox"/> (<input type="checkbox"/>) TUBERCULOSIS
<input type="checkbox"/> (<input type="checkbox"/>) BONE DISORDERS	<input type="checkbox"/> (<input type="checkbox"/>) ANEMIA
<input type="checkbox"/> (<input type="checkbox"/>) MITRAL VALVE PROLAPSE	<input type="checkbox"/> (<input type="checkbox"/>) EPILEPSY/SEIZURES
<input type="checkbox"/> (<input type="checkbox"/>) HEART Trouble/Murmurs	<input type="checkbox"/> (<input type="checkbox"/>) PROLONGED BLEEDING
<input type="checkbox"/> (<input type="checkbox"/>) RHEUMATIC TROUBLE	<input type="checkbox"/> (<input type="checkbox"/>) FAINTNESS/BLEEDING
<input type="checkbox"/> (<input type="checkbox"/>) THYROID PROBLEMS	<input type="checkbox"/> (<input type="checkbox"/>) TONSILS REMOVED
<input type="checkbox"/> (<input type="checkbox"/>) DIABETES	<input type="checkbox"/> (<input type="checkbox"/>) ADENOIDS REMOVED
<input type="checkbox"/> (<input type="checkbox"/>) EMOTIONAL PROBLEMS	<input type="checkbox"/> (<input type="checkbox"/>) SORE THROATS
<input type="checkbox"/> (<input type="checkbox"/>) AIDS	<input type="checkbox"/> (<input type="checkbox"/>) TONSILITIS
<input type="checkbox"/> (<input type="checkbox"/>) KIDNEY/LIVER PROBLEMS	<input type="checkbox"/> (<input type="checkbox"/>) EARACHES

HAS ANY FAMILY MEMBER OR CLOSE RELATIVE HAD:
 () RHEUMATOID ARTHRITIS () LUPUS
 LIST ANY OTHER SERIOUS ILLNESSES:

 LIST ANY ALLERGIES:

 LIST DRUGS OR MEDICATIONS NOW BEING TAKEN:

 IS PATIENT PRESENTLY UNDER PHYSICIAN'S CARE? YES NO
 REASON

NAME OF PHYSICIAN

DENTAL HISTORY

PLEASE CHECK YES OR NO...
(Y) (N)

<input type="checkbox"/> (<input type="checkbox"/>) ANY INJURIES TO FACE, MOUTH, TEETH? (circle)
<input type="checkbox"/> (<input type="checkbox"/>) THUMB, FINGER, LIP SUCKING? (circle)
<input type="checkbox"/> (<input type="checkbox"/>) MORE THAN AVERAGE AMOUNT OF DECAY?
<input type="checkbox"/> (<input type="checkbox"/>) ANY MISSING PERMANENT TEETH?
<input type="checkbox"/> (<input type="checkbox"/>) ANY TEETH REMOVED BY EXTRACTION?
<input type="checkbox"/> (<input type="checkbox"/>) ANY DIFFICULTY IN SWALLOWING OR CHEWING?
<input type="checkbox"/> (<input type="checkbox"/>) ANY PAIN OR CLICKING ON OPENING MOUTH?
<input type="checkbox"/> (<input type="checkbox"/>) IS PATIENT ADOPTED? AT WHAT AGE? _____
<input type="checkbox"/> (<input type="checkbox"/>) DOES PATIENT VISIT DENTIST REGULARLY? DATE OF LAST VISIT _____
<input type="checkbox"/> (<input type="checkbox"/>) HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY? REASON: _____
APPROXIMATELY HOW MUCH HAS PAT. GROWN IN LAST YEAR? _____
WHAT WOULD YOU LIKE FOR ORTHODONTICS TO ACCOMPLISH? _____
ADOLESCENT FEMALES: HAS MENSTRATION (PUBERTY) BEGUN? <input type="checkbox"/> YES <input type="checkbox"/> NO DATE (MONTH, YEAR) _____
PATIENT'S ATTITUDE TOWARD ORTHODONTIC TREATMENT: (circle one) VERY MOTIVATED - WILL COOPERATE IF NEEDED - NOT MOTIVATED

We are sorry that we cannot accept divorce decrees as assignment of responsibility for a child's orthodontic bills. The parent accompanying the child should pay for the services and seek any reimbursement from the other parent. To the best of my knowledge, the above information is complete and correct. I give my permission for any photographs, x-rays, or study models to be used for display at scientific meetings, presentations, and publications of a scientific nature or for study group purposes to further the art and science of orthodontics. I, the undersigned, agree to pay attorney fees and other costs of collection in the event it becomes necessary to use attorney services to secure payment of this account. I understand Johnston & Doris Orthodontics, can obtain a credit history if he needs to extend credit. **(Please sign and date)**