



1303 Main Street, Daphne, Alabama 36526 PHONE (251) 626-7770 FAX (251) 626-7770

WE WOULD LIKE TO WELCOME YOU TO OUR OFFICE. PLEASE COMPLETE BOTH SIDES OF THIS FORM. ALL INFORMATION IS CONFIDENTIAL. THANK YOU.

PATIENT INFORMATION

DATE:
PATIENT'S NAME:
PREFERS TO BE CALLED:
ADDRESS:
CITY/STATE/ZIP:
HOME PHONE:
DATE OF BIRTH:
SEX: MALE / FEMALE
SSN:
SCHOOL:
GRADE:
E-MAIL:
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?
NAME AND AGE OF OTHER SIBLINGS:

RESPONSIBLE PARTY INFORMATION (Adult patients, please complete this section)

NAME:
MARITAL STATUS:
RELATIONSHIP TO PATIENT:
SSN:
DATE OF BIRTH:
E-MAIL:
ADDRESS:
HOW LONG AT THIS ADDRESS:
OWN / RENT
PREVIOUS ADDRESS (IF LESS THAN 3 YEARS):
HOME PHONE:
WORK PHONE:
CELL / PAGER:
EMPLOYER:
OCCUPATION:
# YEARS EMPLOYED:
SPOUSE'S NAME:
RELATIONSHIP TO PATIENT:
SSN:
DATE OF BIRTH:
E-MAIL:
WORK PHONE:
CELL / PAGER:
EMPLOYER:
OCCUPATION:
# YEARS EMPLOYED:

DENTAL INSURANCE INFORMATION

INSURED'S FULL NAME:
SSN:
DATE OF BIRTH:
INSURANCE COMPANY:
GROUP #:
CONTRACT/ ID #:
INSURANCE COMPLETE ADDRESS AND PHONE #:
INSURED'S EMPLOYER AND PHONE #:

DO YOU HAVE DUAL COVERAGE? YES / NO IF YES PLEASE FILL IN BELOW

INSURED'S FULL NAME:
SSN:
DATE OF BIRTH:
INSURANCE COMPANY:
GROUP #:
CONTRACT/ ID #:
INSURED'S EMPLOYER AND PHONE #:
INSURANCE COMPLETE ADDRESS:

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT:
ADDRESS:
PHONE:

**MEDICAL AND DENTAL HEALTH INFORMATION**

PATIENT'S DENTIST: \_\_\_\_\_ DATE OF LAST DENTAL VISIT: \_\_\_\_\_

DO YOU NEED A REFERRAL TO A DENTIST? YES / NO

WHAT CONCERNS YOU THE MOST ABOUT YOUR TEETH? \_\_\_\_\_

HAS AN ORTHODONTIST PREVIOUSLY BEEN CONSULTED? YES / NO

ARE ANTIBIOTICS NECESSARY FOR TEETH CLEANING? YES / NO

IS THERE ANY DENTAL WORK THAT NEEDS TO BE COMPLETED PRIOR TO ORTHODONTIC TREATMENT? YES / NO

PATIENT'S PHYSICIAN: \_\_\_\_\_ DATE OF LAST PHYSICAL EXAM: \_\_\_\_\_

IS THE PATIENT UNDER THE CARE OF A PHYSICIAN AT THIS TIME? YES / NO IF YES, PLEASE EXPLAIN: \_\_\_\_\_

LIST ANY MEDICATIONS BEING TAKEN AT THIS TIME: \_\_\_\_\_

LIST ALL ALLERGIES: \_\_\_\_\_

HAS THE PATIENT EVER HAD ANY OF THE FOLLOWING MEDICAL OR DENTAL PROBLEMS?

ABNORMAL BLEEDING	YES / NO	EPILEPSY / CONVULSIONS / SEIZURES	YES / NO	KIDNEY DISEASE	YES / NO
BONE DISORDERS	YES / NO	AIDS / HIV POSITIVE	YES / NO	LIVER DISEASE	YES / NO
CANCER OR TUMOR	YES / NO	HEART PROBLEMS	YES / NO	HIGH BLOOD PRESSURE	YES / NO
DIABETES	YES / NO	HEMOPHILIA / PROLONGED BLEEDING	YES / NO	BRUISE / BLEED EASILY	YES / NO
HEPATITIS	YES / NO	TUBERCULOSIS / POSITIVE PPD	YES / NO	PREGNANT NOW	YES / NO
SINUS PROBLEMS	YES / NO	ASTHMA OR HAYFEVER	YES / NO	HEART MURMUR OR MVP	YES / NO
LATEX ALLERGY	YES / NO	ANEMIA	YES / NO	DISABILITIES	YES / NO
PLASTIC / METAL ALLERGY	YES / NO	FINGER / THUMB SUCKING	YES / NO	MOUTH BREATHING	YES / NO
TOOTH / JAW TRAUMA	YES / NO	LIP / TONGUE BITING	YES / NO	TONGUE THRUST	YES / NO
CLENCHING / GRINDING	YES / NO	TONSILS / ADENOID PROBLEMS	YES / NO	SPEECH PROBLEMS	YES / NO
JAW CLICKING / POPPING	YES / NO	ARTHRITIS / OSTEOPOROSIS	YES / NO	SMOKE / CHEW TOBACCO	YES / NO
PAINFUL JOINTS	YES / NO	ALCOHOLISM / DRUG ADDICTION	YES / NO	EAR INFECTIONS	YES / NO
DENTAL PAIN	YES / NO	FREQUENT COLDS / SORE THROAT	YES / NO	HEADACHES	YES / NO
FAINTING OR DIZZINESS	YES / NO	SEXUALLY TRANSMITTED DISEASE	YES / NO	CAVITIES NOW	YES / NO
COLD SORES / HERPES	YES / NO	BISPHOSPHONATES	YES / NO	EXTRA TEETH	YES / NO
NERVOUS DISORDERS	YES / NO	THYROID PROBLEMS	YES / NO	MISSING PERMANENT TEETH	YES / NO

PLEASE EXPLAIN ANY MEDICAL OR DENTAL PROBLEMS THAT YOU HAVE HAD: \_\_\_\_\_

**AFFIRMATION**

I AFFIRM THAT THE INFORMATION THAT I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE. IT WILL BE HELD IN THE STRICTEST OF CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE IMMEDIATELY OF ANY CHANGES IN MEDICAL STATUS. I UNDERSTAND THAT WHERE APPROPRIATE, CREDIT REPORTS MAY BE OBTAINED.

\_\_\_\_\_  
PATIENT/PARENT/LEGAL GUARDIAN

\_\_\_\_\_  
DATE

**OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY**

I VERBALLY REVIEWED THE MEDICAL / DENTAL INFORMATION ABOVE WITH THE PATIENT / PARENT / LEGAL GUARDIAN.

\_\_\_\_\_  
SIGNED

\_\_\_\_\_  
DATE