Account # _____
First Contact Date: _____
Exam Date: _____

Confidential Responsible Party Information

A B C

Name _____ Marital Status _____
Last First Middle

Residence _____ Own Rent
Street City State Zip

Mailing Address _____ Email _____

How long at this address _____ Previous Address (if less than 3 yrs) _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security# _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouses's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Work Phone#: _____

Social Security # _____ Birthdate _____ Cell Phone #: _____

Confidential Patient Information

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Soc Sec. # _____

If patient is a minor, give parent's or guardians' name _____

Whom may we thank for referring you to our office? _____ Dentist: _____

Orthodontic / Dental Insurance Information

Policy Holder's Name _____ and Soc Sec. # _____

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 _____ and Soc. Sec. # _____

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 _____

Phone _____ Relationship to Patient: _____

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)

PLEASE COMPLETE THE SECTION THAT IS APPLICABLE TO THE PATIENT

CHILD DENTAL HISTORY

What are your main orthodontic concerns? _____

_____

_____

Sibling Name _____ DOB _____
Sibling Name _____ DOB _____
Sibling Name _____ DOB _____

Have adenoids or tonsils been removed? Y N
Has your child ever been evaluated or had orthodontic treatment before? Y N
Have there been any injuries to the face, mouth, teeth or chin? Y N

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS?

Y	N	Abnormal Bleeding	Y	N	Diabetes
Y	N	Allergies to any Drugs	Y	N	Handicaps / Disabilities
Y	N	Allergic to Latex / Metals	Y	N	Hearing Impairment
Y	N	Allergic to Plastic	Y	N	Heart Murmur
Y	N	Any Hospital Stays	Y	N	Hemophilia
Y	N	Any Operations	Y	N	Hepatitis
Y	N	Asthma	Y	N	HIV+ / AIDS
Y	N	Snoring	Y	N	Kidney Problems
Y	N	Cancer	Y	N	Liver Problems
Y	N	Congenital Heart Defect	Y	N	Rheumatic / Scarlet Fever
Y	N	Convulsions / Epilepsy	Y	N	Tuberculosis (TB)

Please discuss any medical problems that your child has had:

_____

_____

_____

DOES / DID YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS?

Y	N	Grinding	Y	N	Thumb / Finger Sucking
Y	N	Mouth Breather	Y	N	Tongue Thrust
Y	N	Speech Problems			

ADULT DENTAL HISTORY

What are your main orthodontic concerns? _____

_____

_____

Have you ever had or been evaluated for orthodontic treatment? Y N
Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ/TMD)? Y N
Do your gums ever bleed? Y N
Do you have any speech problems? Y N
Do you snore? Y N
Do you generally breathe through your mouth? Y N
Y N Awake? Y N Asleep? (Please circle one)
Do you have missing or extra permanent teeth? Y N
Are you pregnant? Y N Week# _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS?

Y	N	Anemia	Y	N	Heart Surgery
Y	N	RadiationTreatment	Y	N	Pacemaker
Y	N	Artificial Bones / Joints	Y	N	Hemophilia / Abnormal Bleeding
Y	N	Artificial Valves	Y	N	Hepatitis
Y	N	Asthma	Y	N	High Blood Pressure
Y	N	Arthritis	Y	N	Low Blood Pressure
Y	N	Cancer / Chemotherapy	Y	N	HIV+ / AIDS
Y	N	Congenital Heart Defect	Y	N	Hospitalized for Any Reason
Y	N	Diabetes / Tuberculosis (TB)	Y	N	Kidney Problems
Y	N	Difficulty Breathing	Y	N	Mitral Valve Prolapse
Y	N	Drug / Alcohol Abuse	Y	N	Psychiatric Problems
Y	N	Emphysema	Y	N	Rheumatic Fever
Y	N	Glaucoma	Y	N	Scarlet Fever
Y	N	Epilepsy / Seizures	Y	N	Severe / Frequent Headaches
Y	N	Fainting Spells	Y	N	Shingles
Y	N	Fever Blisters / Herpes	Y	N	Sinus Problems
Y	N	Heart Attack	Y	N	Ulcers
Y	N	Stroke	Y	N	Colitis
Y	N	Heart Murmur	Y	N	Venereal Disease

Please list any serious medical conditions that you have ever had:

_____

_____

Please circle if the patient has or is currently taking any of the following medications (Intravenously or Orally).

Fosomax: Y N Actonel: Y N Bisphosphonates: Y N Skelid Y N Reclast Y N
Zometa: Y N Aredia: Y N Didronel Y N Boniva: Y N

Is the patient allergic to any of the following?

Y	N	Aspirin	Y	N	Dental Anesthetics	Y	N	Penicillin
Y	N	Any Metal/Plastics	Y	N	Erythromycin	Y	N	Tetracycline
Y	N	Codeine	Y	N	Latex	Y	N	Other

Please list any other allergies that the patient has: _____

_____

Family Physician: _____
Phone#: ( ) _____ Date of last visit: _____
Are you under the care of a physician? Y N
Please explain: _____
Are you taking any prescription/over-the-counter drugs? Y N
Please list each one: _____

_____

I understand the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and is my responsibility to inform this office of any changes in my/my child's medical status. I authorize the dental staff to perform any necessary dental services that I or my child may need during diagnosis and treatment with informed consent.

_____ _____ _____
Signature Relationship to patient Date

Thank you for filling out this form completely.

KING ORTHODONTICS