NEW PATIENT CONSULTATION FORM

TODAY'S DATE _____

PATIENT INFORMATION

PATIENT'S NAME _____

ADDRESS _____

_____

HOME PHONE _____ WORK PHONE _____

MOBILE PHONE _____ E-MAIL _____

BIRTHDAY _____ AGE _____ SEX _____ SOCIAL SECURITY # _____ — _____ — _____

RESPONSIBLE PARTY INFORMATION

NAME _____ RELATIONSHIP TO PATIENT_____

ADDRESS _____ HOME PHONE _____

_____ WORK PHONE _____

MOBILE PHONE _____ E-MAIL _____

EMPLOYED AT _____ POSITION HELD _____

INSURANCE INFORMATION

DENTAL INSURANCE COMPANY_____

INSURED'S NAME _____ SOCIAL SECURITY # _____ — _____ — _____

INSURED'S BIRTHDAY _____ GROUP NUMBER _____

DO YOU OR YOUR SPOUSE HAVE OTHER DENTAL INSURANCE? YES _____ NO _____

IF YES, PLEASE COMPLETE THE FOLLOWING:

SECONDARY INSURANCE COMPANY _____

SECONDARY INSURED'S NAME _____ S.S. # _____ — _____ — _____

SECONDARY INSURED'S BIRTHDAY _____ GROUP NUMBER _____

MEDICAL AND DENTAL HISTORY

DENTAL INFORMATION

WHAT IS THE ***PRIMARY*** REASON YOU ARE SEEKING ORTHODONTIC TREATMENT AT THIS TIME?

_____

DO YOU HAVE A HISTORY OF A PACIFIER OR FINGER SUCKING HABIT?	YES____	NO____
IS THERE A HISTORY OR CLENCHING OR GRINDING OF THE TEETH?	YES____	NO____
HAS THERE EVER BEEN ANY JAW JOINT NOISES? (POPS, CLICKS, ETC.)	YES____	NO____
HAS THERE EVER BEEN A HISTORY OF, OR IS THERE CURENTLY ANY JAW JOINT PAIN?	YES____	NO____
IS THERE ANY HISTORY OF INJURY OR TRAUMA TO THE FACE AND/OR TEETH?	YES____	NO____
HAVE YOU HAD A DENTAL EXAMINATION WITHIN THE PAST SIX MONTHS?	YES____	NO____

PLEASE LIST THE NAME OF YOUR PRIMARY FAMILY DENTIST AND THE CITY THEY PRACTICE IN:

_____

MEDICAL INFORMATION

HAVE YOU HAD OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING?

HEART MURMUR	YES___ NO___	CHEMOTHERAPY	YES___ NO___	ANEMIA	YES___ NO___
RHEUMATIC FEVER	YES___ NO___	HEPATITIS TYPE A	YES___ NO___	EPILEPSY	YES___ NO___
ANGINA PECTORIS	YES___ NO___	HEPATITIS TYPE B	YES___ NO___	FAINTING SPELLS	YES___ NO___
PACEMAKER	YES___ NO___	HEPATITIS TYPE C	YES___ NO___	TUBERCULOSIS	YES___ NO___
HEART SURGERY	YES___ NO___	HEPATITIS TYPE D (OR E)	YES___ NO___	CHRONIC COUGH	YES___ NO___
MITRAL VALVE PROLAPSE	YES___ NO___	ARTHRITIS	YES___ NO___	EMPHYSEMA	YES___ NO___
PROSTHETIC HEART VALVE	YES___ NO___	RHEUMATISM	YES___ NO___	ASTHMA	YES___ NO___
ARTERIOSCLEROSIS	YES___ NO___	CORTISONE MEDICATION	YES___ NO___	HAY FEVER	YES___ NO___
HEART DISEASE	YES___ NO___	HIGH BLOOD PRESSURE	YES___ NO___	STOMACH ULCER(S)	YES___ NO___
HEART ATTACK	YES___ NO___	LOW BLOOD PRESSURE	YES___ NO___	SINUS PROBLEMS	YES___ NO___
IRREGULAR HEART BEAT	YES___ NO___	STROKE	YES___ NO___	BLEEDING PROBLEMS	YES___ NO___
ARTIFICIAL JOINT	YES___ NO___	SURGICAL PINS OR PLATES	YES___ NO___	DRUG ADDICTION	YES___ NO___
DIABETES	YES___ NO___	LIVER DISEASE	YES___ NO___	SICKLE CELL ANEMIA	YES___ NO___
AIDS, ARC OR HIV	YES___ NO___	KIDNEY DISEASE	YES___ NO___	BLOOD TRANSFUSION	YES___ NO___
CANCER	YES___ NO___	THYROID PROBLEMS	YES___ NO___	PSYCHIATRIC CARE	YES___ NO___
RADIATION THERAPY	YES___ NO___	LEUKEMIA	YES___ NO___	GLAUCOMA	YES___ NO___

WOMEN ONLY: ARE YOU CURRENTLY PREGNANT OR PLANNING ON BECOMING PREGNANT? YES____ NO____

PLEASE LIST ANY MEDICAL CONDITIONS YOU MAY HAVE THAT ARE NOT SPECIFICALLY LISTED ABOVE:

PLEASE LIST ANY ALLERGIES (ESPECIALLY LATEX OR NICKEL SENSITIVITY):

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

PATIENT SIGNATURE:_____ DATE:_____

RESPONSIBLE PARTY:_____ RELATIONSHIP:_____

REVIEWED BY:_____ DATE:_____