

PATIENT INFORMATION

Date: _____

Patient's Name: _____
Last First Middle

Address: _____
Street City State Zip

Home Phone: _____ Birthdate: _____ School: _____

If Patient is a minor, give parent's or guardian's name: _____

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

RESPONSIBLE PARTY INFORMATION

Name: _____
Last First Middle

Residence _____
Street City State Zip

Mailing Address: _____
Street City State Zip

How long at this address: _____ Home Phone: _____ Work Phone: _____

Precious Address (if less than 3 yrs.): _____
Street City State Zip

Social Security #: _____ Birthdate: _____ Relationship to Patient: _____

Employer: _____ Occupation: _____ No. Years Employed: _____

If military, pay grade: _____ Email Address: _____

Spouse Name: _____ Relationship to Patient: _____
Last First Middle

Employer: _____ Occupation: _____ No. Years Employed: _____

Social Security # _____ Birthdate: _____ Work Phone: _____

INSURANCE INFORMATION

Insured Name: _____ Insured Soc. Sec #: _____

Birthdate: _____ Employer: _____

Insurance Company Name: _____ Group No. : _____

Insurance Co. Address: _____

Insurance Co. Phone Number: _____

Do you have dual coverage? Yes No If yes:

Insured Name: _____ Insured Soc. Sec. #: _____

Birthdate: _____ Employer: _____

Insurance Co. Address: _____

Insurance Co. Phone Number: _____

EMERGENCY INFORMATION

Name of nearest relative not living with you: _____

Complete Address: _____

Phone: _____

MEDICAL HISTORY OF PATIENT**CIRCLE ONE**

Has there been any history of joint swelling, heart trouble, asthma, TB, AIDS, kidney, or liver ailment, epilepsy, rheumatic fever or other major illness? Yes* No * (If yes circle all that apply)

Is there a tendency to faint or become dizzy? Yes No

Have tonsils or adenoid been removed? Yes No

Does the Patient bleed easily, or is bleeding hard to stop? Yes No

Are there any allergies? (sulpha, penicillin, novacaine, others) Yes No

Are medicines now being taken? List: _____ Yes No

Is the patient under the care of a physician at represent? Yes No

Have medical X-rays been taken in the past 6 months? Yes No

Has menses occurred? If yes, age_____ If not, can age be predicted? _____

DENTAL HISTORY OF PATIENT

Have there been any injuries to the teeth? (falls, blows, chips, etc.) Yes No

Were there any teeth removed by extraction? Yes No

 Was it suggested that the space be maintained? Yes No

 Was an appliance placed? Yes No

Does the patient breathe through the mouth, or are the lips parted? Yes No

Were there habits that might have caused teeth to move? Yes No
(Lip or nail biting, thumb sucking, etc.)

Is there any clicking or popping of the jaw? Yes No

Do you have frequent headaches or neck pain? Yes No

Do you grind your teeth at night? Yes No

Do you have muscle soreness in the face? Yes No

Have you ever been in an accident involving the teeth, jaw, or face? Yes No

Has an orthodontist been consulted previously? Yes No

Have we treated any other family members? Yes No

What would you most like to have orthodontic treatment accomplish? _____

Approximately when was the last dental care? _____

Remarks _____

Signature (Parent's signature if minor) * _____

**By signing, I agree that the information is true to the best of my knowledge. I have received the Privacy Policies of Jack J. Rosenberg, D.D.S., P.C. I understand that where appropriate, credit bureau reports may be obtained.*