PATIENT INFORMATION

PATIENT'S FULL NAME____

NICKNAME _________________________________ DATE ______________________________________

ADDRESS_____________________________________CITY_______________STATE_________ZIP_______

BEST PHONE NUMBER TO BE REACHED _______________________ BIRTHDATE____________________

If Patient is a minor, please give parents' or guardians' name(s)____

NAMES OF OTHER FAMILY MEMBERS WE HAVE TREATED______________________________________

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?__________________________________

MEDICAL HISTORY

HAS THE PATIENT EVER BEEN TREATED FOR THE FOLLOWING?

Diabetes	Yes No	Tuberculosis	Yes No	Endocrine or Thyroid	Yes No
Pneumonia	Yes No	Anemia	Yes No	Prolonged Bleeding	Yes No
Heart failure	Yes No	Epilepsy	Yes No	Liver disease	Yes No
Bone disorders	Yes No	Asthma	Yes No	Fainting or Dizziness	Yes No
Rheumatic Fever	Yes No	Kidney disease	Yes No	Nervous disorders	Yes No

IS THE PATIENT IN GOOD HEALTH?____

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN AND PLEASE GIVE REASONS_______________

____

DOES THE PATIENT HAVE ANY HISTORY OF MAJOR ILLNESS?____________________________________

PLEASE LIST ANY ALLERGIES OR DRUG SENSITIVITY____

HAVE TONSILS AND ADENOIDS BEEN REMOVED? WHAT AGE?_____________________________________

HOW MUCH GROWTH HAS OCCURRED IN THE LAST 6 MONTHS?___________________________________

HAS THE PATIENT REACHED PUBERTY?____

HEIGHT: PATIENT_______________ MOTHER______________ FATHER________________________________

PATIENT'S PHYSICIAN____________________________________ LAST SEEN___________________________

DENTAL HISTORY

HAVE THERE BEEN ANY INJURIES TO THE FACE, MOUTH, OR TEETH? YES NO. IF YES, WHAT WAS INJURED?____

HAS THE PATIENT EVER SUCKED A THUMB OR FINGER? UNTIL WHAT AGE?________________________

DOES THE PATIENT CLENCH OR GRIND THEIR TEETH? YES NO

DOES THE PATIENT HAVE ANY CLICKING OR DISCOMFORT IN THE JAW JOINTS? YES NO

HAVE YOU EVER BEEN INFORMED OF ANY MISSING OR EXTRA TEETH? YES NO

HAS THE PATIENT HAD ANY PREVIOUS ORTHODONTIC EXAMINATIONS? YES NO

IS THE PATIENT ANXIOUS TOWARD DENTAL VISITS? YES NO

DOES THE PATIENT HAVE ANY CONGENTIAL ABNORMALITIES? YES NO. IF YES, PLEASE EXPLAIN____

PATIENT'S DENTIST______________________________________ LAST SEEN___________________________

RESPONSIBLE PARTY INFORMATION

NAME ____

MARITAL STATUS______________________________ SPOUSE'S NAME_____________________________

MAILING ADDRESS ____

EMAIL ADDRESS ____

CELL PHONE (w/ area code) ____---_

HOW LONG AT THIS ADDRESS?_____________HOME PHONE (w/ area code) __________________________

PREVIOUS ADDRESS (If less than 3 years) ____

HOW LONG AT YOUR PREVIOUS ADDRESS?____

RELATIONSHIP TO PATIENT IF APPLICABLE ____

RESPONSIBLE PARTY'S DATE OF BIRTH ____

EMPLOYER ___________________________________ OCCUPATION ________________________________

OF YEARS EMPLOYED________________________

EMPLOYER ADDRESS AND PHONE NUMBER (w/ area code) _______________________________________

____

PREVIOUS EMPLOYER ADDRESS AND PHONE NUMBER (If less than 3 years) ________________________

____

INSURANCE INFORMATION

INSURED'S NAME ______________________________ INSURANCE CO______________________________

ID# or SOCIAL SECURITY #________________________ INSURED'S DATE OF BIRTH__________________

EMERGENY INFORMATION

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU ____

COMPLETE ADDRESS AND PHONE # ____

____

I CERTIFY THAT ALL THE ABOVE INFORMATION IS CORRECT. IF THERE ARE ANY CHANGES I WILL NOTIFY DR. ALTHERR'S OFFICE.

____ _______________________________________

Signature Date