**Oakwell Farms Orthodontics**

**Patient Information Form**

Patients Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First Middle

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip

Birthdate\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_

If patient is a minor, Name of parent or guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First MI Marital Status

Mailing Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip

How long at this address?\_\_\_\_\_\_\_ Home Ph\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Ph\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SS#\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_ Birthdate\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_ Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Years Employed\_\_\_\_\_\_\_\_\_\_\_

Spouse’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SS#\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ Birthdate\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No. Years Employed\_\_\_\_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

Subscriber’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_

Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have dual coverage? (Two insurances?) \_\_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_No

Secondary Insurance Company Name & Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #\_\_\_\_\_\_\_\_\_\_\_\_ Telephone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name & Phone # of nearest relative NOT in your home**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are the main concerns that you would like orthodontics to accomplish?

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you/child been evaluated or had orthodontic treatment before? \_\_\_\_\_\_\_\_ Y \_\_\_\_\_\_\_ N**

**Have there been any injuries to the face, mouth, teeth, or chin? \_\_\_\_\_\_\_\_ Y \_\_\_\_\_\_\_ N**

**List any musical instruments played: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have adenoids or tonsils been removed? \_\_\_\_\_\_ Y \_\_\_\_\_\_ N**

**Missing/Extra permanent teeth? \_\_\_\_\_ Y \_\_\_\_\_ N Pain/Tenderness (TMJ/TMD) \_\_\_\_\_\_ Y \_\_\_\_\_\_ N**

**Do you/child brush daily? \_\_\_\_ Y \_\_\_\_ N Floss Daily? \_\_\_\_ Y \_\_\_\_\_ N Do gums bleed \_\_\_\_\_ y \_\_\_\_ N**

**Physician’s Name and Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you/child under care of a physician? \_\_\_\_\_\_ Y \_\_\_\_\_\_ N Last Visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**List all drugs you/child are currently taking \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**List all drugs that you/child are allergic to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**List Name & Phone of General Dentist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Last Cleaning: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CHILDREN: Has puberty begun? \_\_\_\_\_\_\_\_ Y \_\_\_\_\_\_\_ N Menstruation? \_\_\_\_\_\_ Y \_\_\_\_\_ N**

**Describe child’s physical health \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WOMEN Are you pregnant? \_\_\_\_\_\_\_\_\_ Nursing? \_\_\_\_\_\_\_\_ Taking oral contraceptives? \_\_\_\_\_\_\_\_\_**

**ADULTS/CHILDREN**

**Have you/child had any of the following problems? (Circle Y or N)**

**Y N Abnormal bleeding Y N Diabetes**

**Y N Anemia/Radiation treatment Y N Hearing Impairment**

**Y N Artificial bones/joints Y N High/Low blood pressure**

**Y N Asthma Y N HIV+/AIDS**

**Y N Allergy to plastic/Latex Y N Hospitalized? Reason? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Y N Blood transfusion Y N Kidney problems**

**Y N Cancer/Chemotherapy Y N Psychiatric problems**

**Y N Fever blisters/Herpes Y N Emphysema/Glaucoma**

**Y N Shingles Y N Drug/Alcohol Abuse**

**Y N Severe/Frequent headaches Y N Rheumatic fever? Pre-med Y N**

**Y N Venereal Disease Y N Heart attack/stroke/murmur? Pre-med Y N**

**Y N Epilepsy/Seizures/Fainting Y N Mitral valve prolapsed? Pre-med Y N**

**Y N Ulcers/Colitis Y N Heart surgery/Pacemaker? Pre-med Y N**

**Y N Sinus problems Y N Congenital Heart Defect? Pre-med Y N**

**Please list any serious medical condition(s)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I understand that 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 it is my responsibility to inform**

**this office of any changes in my 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 my informed consent. I give**

**consent for this office to give school officials information in relation to attendance when questioned.**

**I authorize this office to file insurance claims and collect payment according to procedure once treatment**

**begins. I also understand that if my coverage changes or terminates during treatment. I will assume responsibility of the account.**

**Signature Date**