Date: _____

Patient's Name: _____ Nickname: _____ (if preferred)

Address: _____ Home Phone: _____

_____ Cell Phone: _____

Parent's

Birth Date: ____ / ____ / ____ Age: ____ Sex: ____ Marital Status: _____

Father's Name: _____ Occupation: _____

SSN: _____ Birthday: _____

Employer: _____ Bus. Phone: _____

Mother's Name: _____ Occupation: _____

SSN: _____ Birthday: _____

Employer: _____ Bus. Phone: _____

What is your relationship to the patient? _____

Person Responsible For Payment Of Account: _____

Responsible Party's Email Address: _____

Address, If Different Than Above: _____

Responsible Party's Home Phone: _____ Bus. Phone: _____

Patient's Dentist: _____ Last Visit: _____

Physician: _____

Referred By: _____ Ages Of Other Children: _____

School: _____ Grade: _____

Will Treatment Be Covered By Orthodontic Insurance? _____

If Yes, List Carrier: _____

Has Patient Ever Been Examined By An Orthodontist? _____

Have we treated another member of your family? _____

Who? _____ Why? _____

Is Patient Under The Care Of A Physician Now? _____

Has Patient Ever Had: Asthma? _____ Epilepsy? _____

Diabetes? _____ Major Illness? _____ Allergic Reactions? _____

What is your primary concern about your teeth? _____