Date: _____

Patient's Name: _____ Nickname: _____

Address: _____ Home Phone: _____

_____ Cell: Phone: _____

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

Occupation: _____ SSN: _____

Employer: _____ Bus. Phone: _____

Spouse's Name: _____ Occupation: _____

SSN: _____ Birthdate: _____

Employer: _____ Bus. Phone: _____

Person Responsible For Payment Of Account: _____

Address, If Different Than Above: _____

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

Patient's Dentist: _____ Last Visit: _____

Physician: _____

Referred By: _____ Ages Of Children: _____

Will Treatment Be Covered By Orthodontic Insurance? _____

If Yes, List Carrier: _____

Has Patient Ever Been Examined By An Orthodontist? _____

Is Patient Under The Care Of A Physician Now? _____

Has Patient Ever Had: Asthma? _____ Rheumatic Fever? _____

Heart Murmur? _____ Hemophelia? _____ Allergic Reactions? _____

In Your Own Words, What Is The Problem? _____

_____