



Date: _____

Fort Worth Office
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Patient Information

Name _____
LAST FIRST MIDDLE
 Email (Home) _____ (Work) _____
 Home Address _____
STREET CITY/STATE ZIP
 Home Phone _____ Birthdate _____ Age _____ Social Security No. _____
 School/Employer _____
 If patient is a minor, give parent or guardian's name _____
 Whom may we thank for referring you to our office? _____

Responsible Party Information

(this portion must be filled out completely)

Name _____ S M D W
LAST FIRST MIDDLE Marital Status
 Email (Home) _____ (Work) _____
 Home Address _____ Own Rent
STREET CITY/STATE ZIP
 Mailing Address _____
STREET CITY/STATE ZIP
 How long at this address? _____ Home Phone _____ Work Phone _____ Cell Phone _____
 Previous Address (if less than 3 years) _____
 Social Security No. _____ Birthdate _____ Relationship to Patient _____
 Employer _____ Occupation _____ No. Years Employed _____

Responsible Party Spouse Information

Spouse's Name _____ Relationship to Patient _____
 Email (Home) _____ (Work) _____
 Employer _____ Occupation _____ No. Years Employed _____
 Social Security No. _____ Birthdate _____ Work Phone _____ Cell Phone _____

Primary Dental Insurance Information

Insured's Name _____ Insured's Social Security No. _____
 Email (Home) _____ Insured's Birthdate _____ Group No. _____
 Insurance Company _____ Member ID No. _____
 Insurance Co. Address _____ Phone _____

Secondary Dental Insurance Information

Insured's Name _____ Insured's Social Security No. _____
 Email (Home) _____ Insured's Birthdate _____ Group No. _____
 Insurance Company _____ Member ID No. _____
 Insurance Co. Address _____ Phone _____

I understand that, where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____ Updates (dates & initials) _____

Emergency Information - Not living with Patient or Responsible Party

Name of Emergency Contact _____ Relationship to Patient _____
Address _____
Home Phone _____ Work Phone _____ Cell Phone _____

Medical History

Physician _____ Date of last visit _____
Address _____ Phone _____

Please circle Yes or No (if Yes, please fill in details)

Yes No Are you taking any medication(s)?
Yes No Are you allergic to any medication(s)?
Yes No Do you have a history of a major illness?
Yes No Have you had any major operations?
Yes No Have you ever been involved in a serious accident?

Check any of the medical conditions below that you have had or currently have

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Abnormal bleeding/Hemophilia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis/Liver problems | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Herpes | <input type="checkbox"/> Prolonged Bleeding |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Radiation/Chemotherapy |
| <input type="checkbox"/> Asthma/Hayfever | <input type="checkbox"/> Gastrointestinal Disorders | <input type="checkbox"/> HIV/Aids | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bone Disorders | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumor/Cancer |

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

Dental History

Dentist _____ Date of last visit _____

What concerns you most about your teeth? _____

Goals desired in seeking orthodontic care? _____

Please circle Yes or No (if Yes, please fill in details)

Yes No Are you presently in any dental pain? _____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
Yes No Have you ever injured any teeth? _____
Yes No Have there been any injuries to your face, mouth or teeth? _____
Yes No Is any part of your mouth sensitive to temperature or pressure? _____
Yes No Do your gums bleed when you brush? _____
Yes No Do you have any type of thumb or tongue habit? _____
Yes No Are you a mouth breather? _____
Yes No Have you ever seen an orthodontist? If yes, who and when? _____
Yes No Is your attitude positive toward receiving orthodontic treatment? _____
Yes No Has anyone in your family received orthodontic treatment? _____
How did they feel about the result? _____
Yes No Do your teeth or jaws ever feel uncomfortable when you wake up in the morning? _____
Yes No Are you aware of your jaw clicking or popping? _____
Yes No Are you aware of clenching your teeth during the day? _____
Yes No Have you ever been told that you grind your teeth? _____
Yes No Do you have "tension" headaches? _____
Yes No Have you ever experienced chronic ringing in your ears? _____
Yes No Are you aware that some appointments will be during school/work hours? _____
If the patient is under age 16, height of parents? Mom _____ Dad _____ Patient _____
Please list some hobbies or interests _____

Yes No Are you pregnant? Due Date _____
If patient is under the age of 18, age menstruation began _____

If patient is under the age of 18, age voice changed _____

Patient Signature _____ Date _____

Patient/Guardian Signature _____ Date _____