KUPERMAN

Date: _____

Fort Worth Office
4200 Bryant Irvin Road, Suite 117
Fort Worth, Texas 76109
PHONE: (817) 731-8401
FAX: (817) 377-4317
EMAIL: info@kupermanortho.com

Burleson Office
240 SW Wilshire Boulevard
Burleson, Texas 76028
PHONE: (817) 295-7124
FAX: (817) 377-4317
EMAIL: info@kupermanortho.com

Patient Information

Name _____ Birthdate _____ Age _____
LAST FIRST MIDDLE

Email (Home) _____ (Work) _____

Home Address _____
STREET CITY / STATE ZIP

Home Phone _____ Social Security No. _____

School / Employer _____ Grade _____ Patient Cell _____

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 _____

Emergency Information - Not living with Patient or Responsible Party

Name of Emergency Contact _____ Relationship to Patient _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

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

Signature (Parents signature if minor) _____ Updates (dates & initials) _____

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

- ☐ Abnormal bleeding/Hemophilia
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma/Hayfever
- ☐ Bone Disorders
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Gastrointestinal Disorders
- ☐ Heart Problems
- ☐ Heart Murmur
- ☐ Hepatitis/Liver problems
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HIV/Aids
- ☐ Kidney Problems
- ☐ Nervous Disorders
- ☐ Pneumonia
- ☐ Prolonged Bleeding
- ☐ Radiation/Chemotherapy
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ 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 _____

Address _____ Phone _____

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 _____

Female Patients only

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

Male Patients only

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

Patient Signature _____ Date _____

Patient/Guardian Signature _____ Date _____