Patient Biographical Information

* First Name:

Middle Initial:

* Last Name:

Nickname:

* Birthdate:

* Gender:

* Address:

* Postal Code:

* Main Phone:

2nd/Cell Phone:

Email:

If patient is a minor, give parent's or guardian's name:

If patient is a minor, who does the patient live with?

Please list the names of any friends or family currently in the practice:

Whom may we thank for referring you to our practice?

Financial Party Information

☐ **Check if the patient is also the person who will be financially responsible for treatment.**

* First Name:

* Last Name:

Marital Status:

Relationship to Patient:

* Birthdate:

* Address:

* Postal code:

* Email:

* Main Phone:

2nd/Cell Phone:

Occupation:

Spouse or Other Parent's First Name:

Middle Initial:

Last Name:

Relationship to Patient:

ID number:

Dental Insurance Information

Policy Holder's Name:

Relationship to Patient:

Insurance Company:

Subscriber ID #

Insurance Plan:

Insurance Co. Phone No.:

Dental History

Dentist Name:

Check-up Frequency:

Last Dental Visit:

MM/YY

Has the patient had an orthodontic consult or treatment?

○ No ○ Yes

If so, when?

*Does the patient need to premedicate prior to dental visit?

○ No ○ Yes

What is the patient's main orthodontic concern?

Patient Motivation for Orthodontic Treatment

Patients often request changes in their bites or faces and relief from pain or discomfort. Please help us to understand your concerns by checking the following information; please be specific (check the words - upper, lower, more, etc.)

Teeth - If your teeth could be changed, how would you like them to change?

- ☐ Straighten Front Teeth
  - ○ Upper ○ Lower ○ Both
- ☐ Straighten Back Teeth
  - ○ Upper ○ Lower ○ Both
- ☐ Move Upper Teeth
  - ○ Forward ○ Backward
- ☐ Move Lower Teeth
  - ○ Forward ○ Backward
- ☐ Eliminate Spaces Between Teeth
  - ○ Upper ○ Lower ○ Both
- ☐ Eliminate Crowding of Teeth
  - ○ Upper ○ Lower ○ Both

- [ ] Make Line of Upper Teeth More Level
- [ ] Other:

Face - If your facial appearance could be changed, what would you change?

- [ ] Move Upper Lip
  - ○ Forward ○ Backward
- [ ] Move Lower Lip
  - ○ Forward ○ Backward
- [ ] Show my teeth when I smile
  - ○ More ○ Less
- [ ] Show my gums when I smile
  - ○ More ○ Less
- [ ] Make my nose:
  - ○ Longer ○ Shorter
- [ ] Move chin:
  - ○ Forward ○ Backward
- [ ] Move chin:
  - ○ Left ○ Right
- [ ] Reduce the strain when I close my lips in my:
  - ○ Chin ○ Lips ○ Both
- [ ] When my teeth touch make my lips:
  - ○ Closer Together ○ Farther Apart

☐ I certify that I have read and understand the above. I acknowledge that I have completed this form to the best of my knowledge, and that my questions have been answered to my satisfaction. I will not hold my orthodontist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. If there is any change later to this history record or medical or dental status, I will inform the practice.

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