



PATIENT INFORMATION

Patient Name Mr. Mrs. Ms. Dr. _____ DOB _____
Address _____ Zip _____
Home Phone _____ Driver's License No. _____ SSN _____
Employer _____ Address _____ Phone _____
Family Dentist _____ Family Physician _____
Nearest Living Relative _____ Relation _____ Phone _____
Address _____ Work Phone _____
Person Responsible for Account _____ Email _____ Cell _____
Name of Insurance _____ Mailing Address _____

MEDICAL INFORMATION (please respond to every question)

A. Yes No Have you ever been hospitalized? Emergency Room? Yes No Explain _____
B. Yes No Are you now under the care of a physician? If yes, why? _____
C. Yes No Are you taking any medications? If yes, what? _____
D. Yes No Are you allergic to anything? If yes, what? _____
E. Yes No Have you ever had a reaction to penicillin or any other drug? If yes, what drug(s)? _____
F. Do you now have or ever had any of the following?
Yes No Yes No Yes No
 Rheumatic Fever Thyroid Disease Birth Defects
 Heart Disease Blood Transfusion Cancer
 Heart Murmur Sickle Cell Disease or Trait AIDS
 Liver Disease Blood Disorders Eye Problems
 Kidney/Bladder Disease Mental Retardation Hearing Problems
 Respiratory Disease Cerebral Palsy Cleft Lip/Palate
 Asthma Hepatitis Speech Problems
 Tuberculosis Diabetes _____
 Anemia Epilepsy OTHER _____
OTHER _____

DENTAL HISTORY / Purpose of this call

Yes No Have you had any previous orthodontist treatment? If yes, when and by whom? _____
 Yes No Have you had any recent dental x-rays? If yes, when and by whom? _____
 Yes No Have you ever had any periodontal therapy? If yes, when? _____ Describe _____
 Yes No Have you ever had injury to face or teeth? If yes, when? _____ Describe _____
 Yes No Do you have any jaw joint problems? If yes, describe _____
 Yes No Do you suffer from frequent headaches? If yes, describe _____
 Yes No Do you grind your teeth? If yes, describe _____

This is to certify that I, the undersigned, consent to the performance of any and all procedures and the use of any and all drugs that are agreed to be necessary or advisable. I also agree to accept full responsibility for the payment of all fees associated with those procedures or drugs, and all costs incurred in the collection of those fees, including collection agency fees, attorney fees, court costs, and venue to be held in Davidson County. Sign ature on file for submission of insurance claims.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

• You may refuse to sign this acknowledgement •
I, _____ have received a copy of this office's Notice of Privacy Practices.

PLEASE PRINT NAME

SIGNATURE

DATE
REVISD 04-08

PATIENT DATE

REVIEWED BY DATE