



Patient Information

Patient's Name: \_\_\_\_\_ [Male] [Female]

Date of Birth: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_

If Patient is a minor, give parent's/guardian's name(s): \_\_\_\_\_

Names/Ages of brothers and sisters: \_\_\_\_\_

Responsible Party Information

Name: \_\_\_\_\_ [Married] [Divorced] [Single]

Custodial Parent: [Mother] [Father] [Both] E-Mail Address: \_\_\_\_\_

Address: \_\_\_\_\_

How long at this address? \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Previous Address (if less then 3 yrs.) \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ No. Years Employed: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ No. Years Employed: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Dental Insurance Information

Primary Secondary
Policy Holder: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

SS# of Policy Holder: \_\_\_\_\_ SS# of Policy Holder: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_/\_\_\_/\_\_\_ Policy Holder's Date of Birth: \_\_\_/\_\_\_/\_\_\_

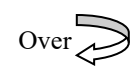
Insurance Company: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Insurance Address: \_\_\_\_\_ Insurance Address: \_\_\_\_\_

Insurance Group/Policy#: \_\_\_\_\_ Insurance Group/Policy#: \_\_\_\_\_

- I hereby authorize the release of any information to other health care providers, insurance companies, and business associates including personal health information as well as administrative data which is not strictly dental or medical in nature. I additionally authorize payment directly to AllSmiles Orthodontics of the insurance benefits otherwise payable to me.
I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.
I certify that the above information is complete and true to the best of my knowledge. I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's if minor): \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_



**Patient's Medical/Dental History**

Patient's Dentist: \_\_\_\_\_ Phone#: (\_\_\_\_) \_\_\_\_\_ Last Visit: \_\_\_\_\_

What is patient's/parent's primary concern: \_\_\_\_\_

Patient's Physician: \_\_\_\_\_ Phone#: (\_\_\_\_) \_\_\_\_\_ Last Visit: \_\_\_\_\_

Is the patient presently being treated by a physician? Yes/No Why?: \_\_\_\_\_

Has the patient's tonsils and adenoids been removed? Yes/No Is child adopted? Yes/No

Has the patient ever had an unusual reaction to any drug? Yes/No Is child aware of adoption? Yes/No

Does the patient have a speech problem? Yes/No If so, are they receiving therapy? Yes/No

Does the patient have any of the following?

- Heart Murmur
- Rheumatic Fever
- Mitral Valve Prolapse
- Pre-Medication Required
- Anemia
- Bleeding Problems
- Gum Problems
- Tuberculosis
- Diabetes
- Epilepsy
- Convulsions/Seizures
- Immune Deficiency
- Smoke Cigarettes/Cigars
- Asthma
- Breathing Problems
- Frequent Colds
- Sinus Problems
- Cold Sores
- ADD/ADHD
- Ulcers
- Thyroid/Hormonal Imbalance
- Lip Biting
- Nail Biting
- Tongue Thrusting
- Presently Suck Thumb/Finger
- Arthritis
- Problems Opening/Closing
- Chewing Problems
- Jaw Popping
- Grinding/Clenching
- Concussion
- Injury to Teeth/Jaws
- Severe Headaches
- Facial Pain
- Any TMJ History
- Nervous Disorder
- Hearing Problem
- Latex Allergy
- Metal Allergy
- Seasonal Allergy
- Other Allergy: List: \_\_\_\_\_
- Major Surgery

Has the patient ever had orthodontic treatment or worn a retainer? Yes/No

Does anyone else in the family have a similar orthodontic problem? Yes/No If so, who: \_\_\_\_\_

If Female: Menstruating? Yes/No Date of First Period: \_\_\_/\_\_\_/\_\_\_

If Male: Voice Change? Yes/No Date Started: \_\_\_/\_\_\_/\_\_\_ Shaving? Yes/No Date Started: \_\_\_/\_\_\_/\_\_\_

Names of Daily Medications? \_\_\_\_\_

Is there any other information about the patient's health we should know? \_\_\_\_\_

**Whom may we thank for referring you to our office?**

Please circle all that apply:

My Dentist    Staff Member at My Dental Office    Selected Doctor from Insurance Provider List

AllSmiles Website    Invisalign Website    Yellow Page Ad    Newspaper Ad in: \_\_\_\_\_

My Friend/Relative Referred Me (list name(s)): \_\_\_\_\_

Other (please specify): \_\_\_\_\_

Signature (Parent's if minor): \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Review by Doctor: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_