



Patient Information

Patient's Name: _____ [Male] [Female]
First Middle Last

Date of Birth: ___/___/___

Address: _____
Street Town State Zip

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]
First Middle Last Marital Status

E-Mail Address: _____

Address: _____
Street Town State Zip

How long at this address? _____ Home Phone: (____) _____ Cell Phone: (____) _____

Previous Address (if less then 3 yrs.) _____
Street Town State Zip

Social Security #: _____ Date of Birth: ___/___/___ Work Phone (____) _____

Employer: _____ Occupation: _____ No. Years Employed: _____

Spouse's Name: _____ Relationship to Patient: _____
First Middle Last

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: _____ Date: ___/___/___

Patient's Medical/Dental History

Patient's Dentist: _____ Phone#: (____) _____ Last Visit: _____

What is patient'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

Has the patient ever had an unusual reaction to any drug? 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: _____

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: _____ Date: ___ / ___ / ___

Review by Doctor: _____ Date: ___ / ___ / ___