3210 OLD SHELL ROAD.MOBILE, AL 36607 PHONE 251.471.8008 FAX 251.471.0018

PATIENT INFORMATION

DATE: _____

PATIENT'S NAME: _____PREFERS TO BE CALLED: _____

MAILING ADDRESS: _____CITY/STATE/ZIP_____

HOME PHONE: _____DATE OF BIRTH: _____SEX: MALE / FEMALE SSN: _____

SCHOOL: _____GRADE: _____E-MAIL: _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

NAME AND AGE OF OTHER SIBLINGS: _____

RESPONSIBLE PARTY INFORMATION
(Adult patients, please complete this section)

NAME: _____MARITAL STATUS: _____ RELATIONSHIP TO PATIENT: _____

SSN: _____DATE OF BIRTH: _____ E-MAIL: _____

ADDRESS: _____ HOW LONG AT THIS ADDRESS: _____ OWN / RENT

PREVIOUS ADDRESS (IF LESS THAN 3 YEARS): _____

HOME PHONE: _____WORK PHONE: _____CELL / PAGER: _____

EMPLOYER: _____OCCUPATION: _____# YEARS EMPLOYED: _____

SPOUSE'S NAME: _____ RELATIONSHIP TO PATIENT: _____

SSN: _____DATE OF BIRTH: _____ E-MAIL: _____

WORK PHONE: _____CELL / PAGER: _____

EMPLOYER: _____OCCUPATION: _____# YEARS EMPLOYED: _____

DENTAL INSURANCE INFORMATION

INSURED'S FULL NAME: _____SSN: _____DATE OF BIRTH: _____

INSURANCE COMPANY: _____ GROUP #: _____ CONTRACT/ ID #: _____

INSURANCE COMPLETE ADDRESS AND PHONE #: _____

INSURED'S EMPLOYER: _____

EMPLOYER'S COMPLETE ADDRESS AND PHONE #:_____

DO YOU HAVE DUAL COVERAGE? ☐ YES IF YES PLEASE FILL IN BELOW

INSURED'S FULL NAME: _____SSN: _____DATE OF BIRTH: _____

INSURANCE COMPANY: _____ GROUP #:_____ CONTRACT/ ID #: _____

INSURED'S EMPLOYER: _____

INSURANCE COMPLETE ADDRESS AND PHONE #:_____

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT: _____

ADDRESS: _____ PHONE: _____

MEDICAL AND DENTAL HEALTH INFORMATION

PATIENT'S DENTIST: _____ DATE OF LAST DENTAL VISIT:_____

DO YOU NEED A REFERRAL TO A DENTIST? ☐ YES

WHAT CONCERNS YOU THE MOST ABOUT YOUR TEETH? _____

HAS AN ORTHODONTIST PREVIOUSLY BEEN CONSULTED? ☐ YES / NO ☐

ARE ANTIBIOTICS NECESSARY FOR TEETH CLEANING? ☐ YES / NO ☐

IS THERE ANY DENTAL WORK THAT NEEDS TO BE COMPLETED PRIOR TO ORTHODONTIC TREATMENT? ☐ YES / NO ☐

PATIENT'S PHYSICIAN: _____DATE OF LAST PHYSICAL EXAM: _____

IS THE PATIENT UNDER THE CARE OF A PHYSICIAN AT THIS TIME? YES / NO IF YES, PLEASE EXPLAIN: _____

_____

LIST ANY MEDICATIONS BEING TAKEN AT THIS TIME: _____

LIST ALL ALLERGIES: _____

_____

HAS THE PATIENT EVER HAD ANY OF THE FOLLOWING MEDICAL OR DENTAL PROBLEMS?

ABNORMAL BLEEDING ☐	EPILEPSY / CONVULSIONS / SEIZURES ☐	KIDNEY DISEASE ☐
BONE DISORDERS ☐	AIDS / HIV POSITIVE ☐	LIVER DISEASE ☐
CANCER OR TUMOR ☐	HEART PROBLEMS ☐	HIGH BLOOD PRESSURE ☐
DIABETES ☐	HEMOPHILIA / PROLONGED BLEEDING ☐	BRUISE / BLEED EASILY ☐
HEPATITIS ☐	TUBERCULOSIS / POSITIVE PPD ☐	PREGNANT NOW ☐
SINUS PROBLEMS ☐	ASTHMA OR HAYFEVER ☐	HEART MURMUR OR MVP ☐
LATEX ALLERGY ☐	ANEMIA ☐	DISABILITIES ☐
PLASTIC/METAL ALLERGY ☐	FINGER / THUMB SUCKING ☐	MOUTH BREATHING ☐
TOOTH/JAW TRAUMA ☐	LIP / TONGUE BITING ☐	TONGUE THRUST ☐
CLENCHING/GRINDING ☐	TONSILS / ADENOID PROBLEMS ☐	SPEECH PROBLEMS ☐
JAW CLICKING/POPPING ☐	ARTHRITIS / OSTEOPOROSIS ☐	SMOKE / CHEW TOBACCO ☐
PAINFUL JOINTS ☐	ALCOHOLISM / DRUG ADDICTION ☐	EAR INFECTIONS ☐
DENTAL PAIN ☐	FREQUENT COLDS / SORE THROAT ☐	HEADACHES ☐
FAINTING OR DIZZINESS ☐	SEXUALLY TRANSMITTED DISEASE ☐	CAVITIES NOW ☐
COLD SORES / HERPES ☐	BISPHOSPHONATES ☐	EXTRA TEETH ☐
NERVOUS DISORDERS ☐	THYROID PROBLEMS ☐	MISSING PERMANENT TEETH ☐

PLEASE EXPLAIN ANY MEDICAL OR DENTAL PROBLEMS THAT YOU HAVE HAD: _____

_____

AFFIRMATION

I AFFIRM THAT THE INFORMATION THAT I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE. IT WILL BE HELD IN THE STRICTEST OF CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE IMMEDIATELY OF ANY CHANGES IN MEDICAL STATUS. I UNDERSTAND THAT WHERE APPROPRIATE, CREDIT REPORTS MAY BE OBTAINED.

_____ _____

PATIENT/PARENT/LEGAL GUARDIAN DATE

I VERBALLY REVIEWED THE MEDICAL / DENTAL INFORMATION ABOVE WITH THE PATIENT / PARENT / LEGAL GUARDIAN.

_____ _____

SIGNED DATE