We would like to welcome you to our office.
Please complete both sides of this form. All information is confidential. Thank you.

Patient Information

Date ______________________

Patient's First Name ______________ Last Name ______________ Middle Name ______

Address ______________ City ______________ State ______ Zip Code ______

Home Phone (___) __________ Birth Date ______ Age ____ Sex ____ Work Phone/Cell (___) __________

If Patient Is A Minor, Give Parent or Guardian's Names ______________________

School ______________ Grade ______ Age and Name of Other Siblings ______________

Patient's Height ______________ Mother's Height ______________ Father's Height ______________

Whom May We Thank For Referring You to Our Office? ______________________

Responsible Party

First Name ______________ Last Name ______________ MI ______ Marital Status ______

Address ______________ City ______________ State ______ Zip Code ______

Mailing Address ______________________

How Long At This Address ______________ Home Phone (___) __________ Work Phone/Cell (___) __________

Previous Address (if less than 3 years) ______________________

Social Security # ______________ Birth Date ______________ Relationship to Patient ______

Employer ______________ Occupation ______________ No. Years Employed ______

Spouse's Name ______________ Last Name ______________ MI ____ Work Phone (___) ______

Social Security # ______________ Birth Date ______________ Relationship to Patient ______

Employer ______________ Occupation ______________ No. Years Employed ______

Dental Insurance Information

Subscriber's Full Name ______________ Soc. Sec.#/ID# ______________ Date of Birth ______

Insurance Company ______________ Group No. ______________ Local No. ______

Insurance Complete Address and Phone # ______________________

Do you have dual coverage? ______________ Yes ❑ Group ❑ **If yes, please fill below:**

Subscriber's Full Name ______________________ Soc. Sec. # ______

Insurance Co. ______________ Group No. ______________ Local No. ______

Insurance Co. Complete Address and Phone # ______________________

Insured's Employer ______________________ Date of Birth ______

Emergency

Name Of Nearest Relative Not Living With You ______________________ Relationship ______

City State and Zip ______________________ Phone (___) ______

I Understand That Where Appropriate, Credit Bureau Reports May Be Obtained.

Signature (*Parent's Signature If Patient Is A Minor*) ______________________

Medical And Dental History

Patient's Dentist ______________________ Last Dental Visit ______________________

Do You Need a Referral To A Dentist?: ______________________

What Concerns Would You Like Orthodontics To Accomplish? ______________________

Indicate The Patient's Feelings Towards Orthodontic Treatment ______________________

Has An Orthodontist Been Previously Consulted? ______________________

Are Antibiotics Necessary For Teeth Cleanings? ______________________

Is There Any Dental Work That Needs To Be Completed Prior To Orthodontic Treatment? ______________________

Physician ______________________ Last Physical Exam ______________________

Is The Patient Under The Care Of A Physician At This Time? Please Explain ______________________

List Any Medications Being Taken At This Time ______________________

List Any Drugs/Things That The Patient Is Allergic To Or Has A Reaction To ______________________

Has The Patient Ever Had Any Of The Following Medical Problems? ______________________

Abnormal Bleeding	Yes	No	Aids/HIV	Yes	No	Diabetes	Yes	No
Plastic/Metal Allergy	Yes	No	Heart Problems	Yes	No	Asthma	Yes	No
Latex Allergy	Yes	No	Cancer Or Tumor	Yes	No	Hepatitis	Yes	No
Epilepsy/Convulsions	Yes	No	Fainting Or Dizzines	Yes	No	Anemia	Yes	No
Thyroid Problems	Yes	No	Pregnant Now	Yes	No	Tuberculosis	Yes	No
Kidney/Liver Problems	Yes	No	Hemophilia	Yes	No	Disabilities	Yes	No
Heart Murmur	Yes	No	High Blood Pressure	Yes	No	Venereal Disease	Yes	No
Finger/Thumb Sucking	Yes	No	Cavities Now	Yes	No	Mouth Breathing	Yes	No
Tooth/Jaw Trauma	Yes	No	Smoke/Chew Tobacco	Yes	No	Headaches	Yes	No
Lip/Tongue Biting	Yes	No	Missing Permanent Teeth	Yes	No	Tongue Thrust	Yes	No
Tonsils/Adenoid Problems	Yes	No	Clenching Or Grinding	Yes	No	Extra Teeth	Yes	No

Please Explain Any Medical Or Dental Problems That The Patient Has Had ______________________

____

Do You Have <u>Any</u> Disease, Medical Or Dental Condition That Is Not Mentioned Above? ______________________

Has the patient ever experienced TMJ symptoms? ______________________

Please explain: ______________________

Any Trauma to face or mouth ______________________

Affirmation

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office immediately of any changes in medical status.

______________________ ______________________

Signature Patient/Parent/Guardian Date

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

Verbally reviewed the medical/dental information above with the patient/parent/guardian and patient named herein.

Signed: ______________________ Date ______________________

1453 West Hays • Boise, Idaho 83702 • 208.345.6287 • Fax 345.0661
450 W. State St. Suite 150 • Eagle, Idaho 83616 • 208.939.7100

LG-1/10-500-10332