

All About Me!!

My name is: _____ But, you can call me _____

I have _____ brother(s) Their names are _____



I have _____ sister(s) Their names are _____



I have _____ pet(s) _____ is a _____



_____ is a _____

_____ is a _____

_____ is a _____

I don't have a pet, but if I did, I'd want a _____

I go to _____ school; I'm in the _____ grade



My favorite color is _____ My favorite class is _____

My favorite sport or activity is _____



My favorite food is _____



If I could go anywhere in the world, I'd go to _____

I want to be a _____ when I grow up!



My favorite kind of car is _____



My favorite holiday is _____



My favorite movie is _____



If I were stranded on a deserted island, the one thing I would want to bring is _____



If I could meet anyone, I would want to meet _____





PATIENT INFORMATION

Today's Date ____ / ____ / ____

Name _____
Last First MI Mr Mrs Ms

Nickname _____ Male ___ Female

Birthday ____ / ____ / ____ Age _____

Home Address _____
City State Zip

Hm # (____) _____ Cell # (____) _____

Wk # (____) _____ Ext. _____ E-mail address _____

Dentist _____ School Attending _____

Who may we thank for referring you to our office? _____

PARENT/GUARDIAN INFORMATION (Fill in if patient is under the age of 18)Parent's Name _____
Last First MI Mr Mrs Ms

___ Step-Parent ___ Guardian

Hm # (____) _____ Cell # (____) _____

Wk # (____) _____ Ext. _____

Parent's Name _____
Last First MI Mr Mrs Ms

___ Step-Parent ___ Guardian

Hm # (____) _____ Cell # (____) _____

Wk # (____) _____ Ext. _____

PERSON RESPONSIBLE FOR ACCOUNT

Relation _____

Name _____
Last First MI Mr Mrs Ms

Email Address _____

(this is necessary if you'd like to have access to your account information online)

Social Security # _____ Driver's License # _____ Birth Date _____

Billing Address _____

City State Zip
Hm # (____) _____ Cell # (____) _____

Wk # (____) _____ Ext. _____

Where & when are best times to reach you? _____

Employer _____ Occupation _____



ORTHODONTIC INSURANCE

Orthodontic Coverage? Yes/No

Dental Coverage? Yes/No

Insurance Co. Name _____

Insurance Co. Address _____

City State Zip

Insurance Co. Phone # (_____) _____ Group # (Plan or Policy #) _____

Insured's Name _____ Insured's Birthday ___ / ___ / ___

Insured's Relation to patient _____

Insured's Employer _____ Insured's Social Security # _____

Employer's Address _____

City State Zip

Dual Insurance Yes/No

Insurance Co. Name _____

Insurance Co. Address _____

City State Zip

Insurance Co. Phone # (_____) _____ Group # (Plan or Policy #) _____

Insured's Name _____ Insured's Birthday ___ / ___ / ___

Insured's Relation to patient _____

Insured's Employer _____ Insured's Social Security # _____

Employer's Address _____

City State Zip

I understand that the information provided is correct to the best of my knowledge. This information will be held in the strictest of confidence and it is my responsibility to inform this office of changes to any information or the patient's medical status. I authorize the orthodontic staff to perform the necessary orthodontic services that the patient may need. I understand that I am responsible for payment of services rendered.

Signature of Patient

Date

Signature of Parent/Guardian (if patient is under the age of 18)

Date



MEDICAL HISTORY

Patient name _____ Date of birth _____
Physician _____ Date of Last Visit _____
Address _____ Phone _____

Please circle Yes or No (If Yes, please fill in details and if don't know please write "don't know")

- Yes No Are you taking any medication? _____
- Yes No Are you allergic to any medication? _____
- Yes No Do you have a history of a major illness? _____
- Yes No Have you had any major operations? _____
- Yes No Have you ever been involved in a serious accident? _____

Circle any of the medical conditions below that you have had or currently have.

- | | | | |
|------------------------------|----------------------------|--------------------------|------------------------|
| Abnormal bleeding/Hemophilia | Diabetes | Hepatitis/Liver problems | Pneumonia |
| Anemia | Dizziness | Herpes | Prolonged Bleeding |
| Arthritis | Epilepsy | High Blood Pressure | Radiation/Chemotherapy |
| Asthma or Hayfever | Gastrointestinal Disorders | HIV / Aids | Rheumatic Fever |
| Bone Disorders | Heart Problems | Kidney problems | Tuberculosis |
| Congenital Heart Defect | Heart Murmur | Nervous Disorders | Tumor or Cancer |
- Are there any medical conditions we have not discussed that you feel we should be aware of? _____

DENTAL HISTORY

Dentist _____ Date of last visit _____

What concerns you most about your teeth? _____

- Yes No Are you presently in any dental pain? _____
- Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
- Yes No Have you ever lost or chipped any teeth? _____
- Yes No Have there been any injuries to face, mouth or teeth? _____
- Yes No Is any part of your mouth sensitive to temperature or pressure? _____
- Yes No Do your gums bleed when you brush? _____
- Yes No Have you had your tonsils/adenoids taken out? _____
- Yes No Do you have any type of thumb or tongue habit? _____
- Yes No Are you a mouth breather? _____
- Yes No Have you had speech problems or speech therapy? _____
- Yes No Have you ever seen an orthodontist? If yes, who and when? _____
- Yes No What is your attitude toward receiving orthodontic treatment? _____
- Yes No Has anyone in your family received orthodontic treatment? _____
- Yes No Did any one in your family have jaw surgery to correct their bite along with orthodontics? _____
- Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
- Yes No Are you aware of your jaw clicking or popping? _____
- Yes No Are you aware of clenching your teeth during the day? _____
- Yes No Have you ever been told that you grind your teeth? _____
- Yes No Do you have "tension" headaches? _____
- Yes No Have you ever experienced chronic ringing in your ears? _____
- Yes No If the patient is under age 16, height of parents? Mom _____ Dad _____
- Yes No Are you aware that some appointments will be during school/work hours? _____

Please list some hobbies or interests _____

Female Patients only:

- Yes No Are you pregnant? _____
- Yes No Has menstruation started? _____

I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Moser to perform a complete orthodontic evaluation.

Signature: _____ Date: _____