

Angela Becker, D.D.S, M.S.D.

Patient Name: _____ Dentist: _____ Last visit date: _____

Birthdate: _____ Age: _____ Sex: M F Home Phone: _____ Cell: _____

Patient's Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ Email: _____

School/Employer: _____ Grade/Position: _____

If Minor, who is accompanying today? _____ Relationship: _____

Primary Contact

Mother Father Step Parent Self Other (specify) _____ Single Married Divorced Other

Responsible Party: _____ Telephone: _____

Social Security Number: _____ Brithdate: _____ Legal Custodian? Y N

Address: _____ City: _____ Zip: _____ Cell: _____

Employer: _____ Email: _____

Secondary Contact

Mother Father Step Parent Self Other (specify) _____ Single Married Divorced Other

Responsible Party: _____ Telephone: _____

Social Security Number: _____ Brithdate: _____ Legal Custodian? Y N

Address: _____ City: _____ Zip: _____ Cell: _____

Employer: _____ Email: _____

Insurance Information

Name of **Primary** Orthodontic Insurance: _____ Telephone: _____

Name of Policy Holder: _____ Mother Father Step Parent Self Other (specify) _____

Subscriber's ID Number: _____ Group Number: _____ Date of Birth: _____

Name of **Secondary** Orthodontic Insurance: _____ Telephone: _____

Name of Policy Holder: _____ Mother Father Step Parent Self Other (specify) _____

Subscriber's ID Number: _____ Group Number: _____ Date of Birth: _____

Whom may we Thank for referring you?

Family/Friend Dentist Referral Hygienist Referral Dr. Becker or Staff Yellow Pages Internet Other

If applicable, name of person we may thank: _____

Please list Siblings/Ages: _____

Health History

Name of Medical Doctor: _____ Telephone: _____

Circle Yes or No for which the patient has had a history:

ADD/ADHD	Y	N	Chronic Neck Pain	Y	N	High Blood Pressure	Y	N
Adenoids/Tonsils Removed	Y	N	Diabetes	Y	N	Immune Problems	Y	N
AIDS	Y	N	Cold Sores/Herpes	Y	N	Kidney Problems	Y	N
Allergies	Y	N	Down Syndrome	Y	N	Latex Allergies	Y	N
_____			Drug Allergies	Y	N	Low Blood Pressure	Y	N
_____			Emotional Disorders	Y	N	Metal Allergies	Y	N
Anemia	Y	N	Epilepsy	Y	N	Muscular Disorders	Y	N
Arthritis	Y	N	Fainting, Dizziness	Y	N	Nervous Disorder	Y	N
Asthma	Y	N	Glaucoma	Y	N	Organ Transplant	Y	N
Auto Immune Disorders/Lupus	Y	N	Handicap/Disability	Y	N	Pneumonia	Y	N
Bone Disorders/Osteoporosis	Y	N	_____			Prolonged Bleeding	Y	N
Bulimia	Y	N	_____			Rheumatic Fever	Y	N
Cancer	Y	N	Headaches	Y	N	Seizures	Y	N
Cerebral Palsy	Y	N	Heart Condition	Y	N	Tuberculosis	Y	N
Chest Pains	Y	N	Hepatitis	Y	N			

Any disease, problems or allergies not mentioned above? _____

Current medications? _____

Is the patient currently pregnant? _____ How many weeks? _____

Dental History Circle Yes or No for which the patient has had a history:

Clicking of Jaw	Y	N	Periodontal Problems	Y	N	Thumb or Finger Sucking	Y	N
Mouth Breathing	Y	N	Speech Problems	Y	N	Tongue Thrust	Y	N
Nail Biting	Y	N	TMJ Problems	Y	N	Tooth Grinding	Y	N
Painful Chewing	Y	N						

Any face, mouth or tooth injuries? _____

Has the patient had a previous orthodontic exam/consultation? _____

What would you like to see accomplished through orthodontics? _____

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 the payment of services rendered. I also acknowledge that I have received a copy of the Notice of Privacy Practices.

I understand that, where appropriate, credit bureau reports may be obtained.

Signature: _____ Relationship to Patient: _____ Date: _____