Patient Information

Date _____

Patient's Name _____ Soc. Sec. # _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Age _____ Sex _____

Patient Work Phone _____ If a minor, give parent or guardian's name _____

Email Address _____ Whom may we thank for referring you? _____

General Dentist _____ Physician _____

Reason for consultation _____

Have you ever been examined by an orthodontist? _____ If yes, when? _____ Had Braces? _____

Sibling's name and age _____

Medical Information

Is patient in good health? . . . . . Yes_____ No_____

Does patient have any history of major illness? . . . . . Yes_____ No_____

Has patient ever been under the care of a physician for illness? . . . . . Yes_____ No_____

If yes, give reason _____

Check any of the following for which the patient has been treated or diagnosed with:

Heart Complications ❑	Emphysema ❑	Venereal Disease ❑	Psychiatric/Psychological Care. ❑
High Blood Pressure ❑	Tuberculosis ❑	A.I.D.S. ❑	Pneumonia ❑
Low Blood Pressure ❑	Asthma ❑	H.I.V. Positive ❑	Bone Disorders ❑
Rheumatic Fever ❑	Latex Sensitivity ❑	Blood Transfusion ❑	Herpes/Cold Sores ❑
Arthritis / Rheumatism ❑	Allergies ❑	Hemophilia/Prolonged Bleeding ❑	Anemia ❑
Kidney Complications ❑	Sinus Trouble ❑	Neurological Disorders ❑	Periodontal Disease ❑
Ulcers ❑	Cancer ❑	Epilepsy or Seizures ❑	Endocrine Problems ❑
Diabetes ❑	Hepatitis A (Infectious) ❑	Fainting or Dizzy Spells ❑	Liver Involvement ❑
Thyroid Problems ❑	Hepatitis B (Serum) ❑	Nervous/Anxious ❑	Hypoglycemia ❑

Does patient take any bisphosphonate medications for osteoporosis, such as Fosamax? _____

Does patient have a tendency to colds? ❑ YES ❑ NO Sore Throats? ❑ YES ❑ NO Ear Infections? ❑ YES ❑ NO

Have tonsils and/or adenoids been removed? ❑ YES ❑ NO At what age? _____

List any drugs or medications now being taken and give reasons _____

List any allergies or drug sensitivity _____

Dental History

Have you had any injuries to the face, mouth or teeth?		❑ YES	❑ NO
Habits:	Thumb or Finger Sucking	❑ YES	❑ NO
	Mouth Breathing	❑ YES	❑ NO
	Nail/Lip Biting	❑ YES	❑ NO
	Grinding or Clenching of Teeth	❑ YES	❑ NO
	Tongue Thrusting	❑ YES	❑ NO
Have you been informed of any missing or extra permanent teeth?		❑ YES	❑ NO

– Over Please –

Financially Responsible Party Information

Name ❑ Ms. ❑ Miss ❑ Mrs. ❑ Mr. ❑ Dr. _____ (Last / First / Middle) ❑ Married ❑ Separated ❑ Single ❑ Divorced

Residence _____ (Street / City / State / Zip)

Mailing Address _____

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (If less than 3 years) _____ (Street / City / State / Zip)

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Do you have orthodontic coverage? ❑ Yes ❑ No Benefit amount: _____ If no, please skip this section.

Insured's Name _____ Insured's Soc. Sec. # _____

Insured's Employer _____ Group No. _____ Local No. _____

Insurance Company Name and Address _____

Insurance Company Phone Number _____

Secondary insurance? ❑ Yes ❑ No Benefit amount: _____

Insured's Name _____ Insured's Soc. Sec. # _____

Insured's Employer _____ Group No. _____ Local No. _____

Insurance Company Name and Address _____

Insurance Company Phone Number _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

Authorization and Release

Please Sign And Initial →

_____ *In accordance with HIPPA regulations, I hereby give my permission for the office of Drs. Richard McLaughlin & Paul Upatham to use patient records and information for diagnosis, treatment planning, promotion, education, and insurance purposes.*

_____ *I authorize the dentist to release any information including the diagnosis, and records for treatment rendered to me or my child if necessary for insurance purposes. I also authorize direct payment of insurance benefits to the dentist for services rendered when indicated.*

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

Signature (Parent's signature if minor) _____

Updates (date & initial) _____ _____ _____ _____

CONFIDENTIAL (For record and pretreatment evaluation)