CONFIDENTIAL PATIENT INFORMATION

Patient Name	DOB	Sex: Male Female
Address	City	State Zip
Home Phone Cell Phone		Email
Whom may we thank for referring you to our office?		
If patient is a minor, give parent or guardian name		

CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

Father's Name (if minor child) or Self	**Mother's Name (if minor child)**
Last First Middle	Last First Middle
Social Security No. DOB	Social Security No. DOB
Home Phone Cell Phone	Home Phone Cell Phone
Email Address	Email Address
Home Address	Home Address
City State Zip	City State Zip
How long at this address? Own Rent Previous address (if less than three years)	How long at this address? Own Rent Previous address (if less than three years)
Employer	Employer
Occupation Years Employed	Occupation Years Employed

DENTAL INSURANCE INFORMATION

Please note that services are covered under your ***dental plan not your ***medical*** plan

Primary Dental Insurance Information:	**Secondary Dental Insurance Information:**
Policy Holder's Name	Policy Holder's Name
Relationship to patient	Relationship to patient
DOB ID No.	DOB ID No.
Insurance Co. Name	Insurance Co. Name
Insurance Co. Address	Insurance Co. Address
Insurance Co. Phone	Insurance Co. Phone
Policy Holder's Employer	Policy Holder's Employer

AUTHORIZATION and PRIVACY NOTICE

I authorize my insurance company to pay to the orthodontist or orthodontic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the orthodontist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. Furthermore, I acknowledge that I have been provided with a notice of PRIVACY POLICIES by Easton Orthodontic Associates.

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

X

Signature (Parent or Guardian's signature if minor)	Print Name	Date

CONFIDENTIAL PATIENT INFORMATION

Patient Name	I prefer to be called
If minor child, attends school at	
Musical instruments played	
Sports/Hobbies	
If minor child, please list any siblings name and age	
Other family members treated here	
What is your primary concern? Why are you here?	
Is patient sensitive or self-conscious about teeth?	
Who suggested that you or your child might need orthodontic treatment?	
Why did you select our office?	
Name of patient's physician	Phone No.
Physician's address	
Date last seen	Reason for visit

MEDICAL HISTORY

Now or in the past, has the patient had:	Yes	No	**Allergies or reactions to any of the following:**
Birth defects or hereditary problems			Penicillin or other antibiotics Yes No
Bone fracture, any major accidents			Latex (gloves, balloons) Yes No
Rheumatoid or arthritic conditions			Foods (specify)
Endocrine or thyroid problems			Other substances (specify)
Kidney problems			Are you currently taking medication? Please name them:
Diabetes			
Cancer, tumor, radiation treatment or chemotherapy			**Does patient need pre-med with antibiotic for dental procedures?** Yes No
Stomach ulcer			
Polio, mononucleosis, tuberculosis, pneumonia			Does patient currently have or ever had a substance abuse problem? Yes No
Problems of the immune system			Does the patient chew or smoke tobacco? Yes No
AIDS or HIV positive			Surgeries? Describe
Hepatitis, jaundice or liver problem			Hospitalized? Describe
Fainting spells, seizures, epilepsy, or neurological problem			Other physical problems or symptoms? Describe
Mental health disturbance or depression			Being treating by another health care professional?
Vision, hearing, tasting or speech difficulties			Describe:
Loss of weight recently, poor appetite			
History of eating disorder (anorexia, bulimia)			Date of most recent physical exam?
Excessive bleeding or bruising tendency, anemia or bleeding disorder			Are there any other medical conditions that we should be aware of?
High or low blood pressure			Describe:
Cardiovascular problem (heart trouble, heart attack, angina, arteriosclerosia, stroke, heart murmur or rheumatic heart disease			**FEMALES ONLY WHEN APPLICABLE:** Has menstruation started? If so, when? ___________________ Is the patient pregnant? Yes No
Eye, ear, nose or throat condition			
Hayfever, asthma, sinus, or hives			
Tonsil or adenoid condition			

CONFIDENTIAL PATIENT INFORMATION

Patient Name	
Name of Patient's Dentist	Phone No.
Dentist's Address	
Date Last Seen	Reason

DENTAL HISTORY

Now or in the past, has the patient had:	Yes	No		Yes	No
Started teething very early or late?			Any pain in jaw or ringing in the ears?		
Primary (baby) teeth removed that were not loose?			Any pain or soreness in the muscles of the face or or around the ears?		
Permanent or "extra" (supernumerary) teeth removed?			Difficulty encountered in chewing or jaw opening?		
Supernumerary (extra) or congenitally missing teeth?			Aware of loose, broken or missing restorations (fillings)?		
Chipped or otherwise injured primary (baby) or permanent teeth?			Any teeth irritating cheek, lip, tongue or palate?		
Teeth sensitive to hot or cold; teeth throb or ache?			Concerned about spaced, crooked or protruding teeth?		
Jaw fractures, cysts or mouth infections?			Aware or concerned about under or over developed jaw?		
"Dead teeth" or root canals treated?			Any relative with similar tooth or jaw relationships?		
Bleeding gums, bad taste or mouth odor?			Had periodontal (gum) treatment?		
Thumb, finger, or sucking habit? Until what age?			Any serious trouble associated with any previous dental treatment?		
Abnormal swallowing habit (tongue thrusting)?			Ever had a prior orthodontic exam or treatment? Specialist name:		
History of speech problems?			Been under another dental specialist's care? Specialist name:		

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signature (Parent or Guardian)	Date
Signature (Dental Staff Member)	Date