Delta
SMILES
Specialists in Orthodontics

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Please fill in the information requested with the boxes on both sides of this form. A signature is required.

PATIENT INFORMATION

Date ______________________________

Patient's Name ______________________________ M ______ F ______
Last First Middle

Address ______________________________
Street City State Zip

Moblie Phone ______________ Birthdate ______________ SS# ______________

Patient's interests ______________ Name/Age of brothers & sisters ______________

If patient is a minor, give parent's or guardian's name ______________________________

Whom may we thank for referring you to our office? ______________________________

RESPONSIBLE PARTY INFORMATION

Name ______________________________ Marital Status ______
Last First Middle

Residence ______________________________
Street City State Zip

Mailing Address ______________________________
Street City State Zip

How long at this address ______________ Moblie Phone ______________ Work Phone ______________

Previous Address (if less than 3 yrs.) ______________________________ Email ______________
Street City State Zip

Social Security # ______________ Birthdate ______________ Relationship to Patient ______________

Employer ______________ Occupation ______________ No. Years Employed ______________

Spouse's Name ______________________________ Relationship ______________
Last First Middle

Employer ______________ Occupation ______________ No. Year Employed ______________

Social Security # ______________ Birthdate ______________ Work Phone ______________

DENTAL INSURANCE INFORMATION

Subscriber's Name ______________ Subscriber's SS# ______________ Birthdate ______________

Insurance Company ______________ Group # ______________ Local # ______________

Insurance Co. Address ______________________________

Subscriber's Employer ______________________________

Do you have dual coverage? Yes No

Subscriber's Name ______________ Subscriber's SS# ______________ Birthdate ______________

Insurance Company ______________ Group No. ______________ Local # ______________

Insurance Company Address ______________________________

Subscriber's Employer ______________________________

I certify that the information on this form is complete and true to the best of my knowledge

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

Signature (Parent's signature if minor) ______________________________

PATIENT'S MEDICAL HISTORY

Patient's Physician: Dr. ______________________ Phone ______________

Has patient had their tonsils or adenoids removed? Yes No

Has patient ever had an unusual reaction to any drug? Yes No

Has patient had any of the following? Yes No

1. Arthritis	Yes	No	9. Diabetes	Yes	No	17. Major surgery	Yes	No
2. Anemia	Yes	No	10. Frequent colds	Yes	No	18. Tuberculosis	Yes	No
3. Bleeding problem	Yes	No	11. Allergies/Sinus	Yes	No	19. Heart trouble	Yes	No
4. Epilepsy/Seizures	Yes	No	12. Asthma	Yes	No	20. Thyroid or Hormonal imbalance	Yes	No
5. Nervous disorder	Yes	No	13. Rheumatic Fever	Yes	No	21. Any other serious medical problems	Yes	No
6. Hyperactivity	Yes	No	14. Immune Deficiency	Yes	No			
7. Hepatitis	Yes	No	15. Herpes/Oral-facial	Yes	No			
8. Venereal disease	Yes	No	16. Ulcers	Yes	No			

Does patient have a speech problem and if so, receiving speech therapy? Yes No

Is patient presently under the care of a physician or taking medication? Yes No

Signature (parent if minor) ______________________ Signature Doctor ______________

Updated ______________ Updated ______________ Updated ______________

PATIENT'S DENTAL HISTORY

Patient's General Dentist: Dr. ______________________ Phone ______________

Does the patient presently suck their thumb or fingers? please circle Yes No

Does the patient breathe mostly through the mouth? Yes No

Has the patient ever received a severe blow resulting in injury to the teeth or jaws?

If yes, please write in details ______________________ Yes No

Does the patient grind their teeth at night? Yes No

In the past, has the patient ever complained of: please circle

Clicking popping stiffness soreness in the jaw or jaw muscles?

Episodes when the jaw would not open or close normally? Yes No

Pain or discomfort in the front of the ear? Yes No

Headaches, neck and or back pain? Yes No

If yes, please write date and details: ______________________

Has patient ever had orthodontic treatment or worn a retainer before? Yes No

Would patient object to wearing orthodontic appl. should they be indicated? Yes No

What is patient's or parent's primary concern? ______________________

____

Comments: ______________________

____

____

EMERGENCY INFORMATION

Name of nearest relative not living with you ______________________

Complete Address ______________________

Phone ______________________ Relationship ______________