Welcome To Our Practice

ADULT PATIENT INFORMATION

Name: First: _____Last:_____ Age _____ Birthdate _____

Nickname _____ ☐ Male ☐ Female

Address _____ City/State _____ Zip _____

Home Phone # _____ Cell Phone # _____

Parent/Guardian Name _____

Have you had previous orthodontic consultations? ☐Yes ☐ No Previous orthodontic treatment? ☐Yes ☐ No

If so, when/where? _____ Doctor's name _____

What is it about your teeth/bite/smile that has brought you to see us? _____

Who may we thank for referring you to Quest Orthodontics ? _____

RESPONSIBLE PARTY INFORMATION

Name _____ Relation to Patient _____ Marital Status S / M / W / D

Address _____ City/State _____ Zip _____

Cell Phone _____ Cell Carrier _____ Work Phone _____

Email Address _____

How would you like to receive your Appointment Reminders? ☐ Text Message ☐ Email ☐ Both

Social Security # _____ - _____ - _____ Birthdate _____

Employer _____ Occupation _____

Spouse's Name (if applicable) _____

Social Security # _____ - _____ - _____ Birthdate _____

Phone # _____ Work Phone # _____

Employer _____ Occupation _____

Name of nearest relative not living with you/Emergency Contact _____

Contact # _____ Work # _____

Address _____ City/State _____ Zip _____

DENTAL INFORMATION

Patient's Dentist _____ Patient's Last Dental Visit _____

Has patient had any unfavorable dental experiences? _____

Does the patient currently have, or has the patient ever had any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Thumb / Finger Sucking	☐	☐	Nail Biting	☐	☐	Missing permanent teeth not due to extraction
☐	☐	Lip Sucking / Lip biting	☐	☐	Nursing/Bottle Habits	☐	☐	Periodontal Disease

MEDICAL INFORMATION

Patient's Overall Health ☐ Excellent ☐ Good ☐ Poor

Is patient currently under the care of a doctor? ☐ Yes ☐ No. If yes, what for _____

Is patient currently taking any medication? ☐ Yes ☐ No. If yes, what for? _____

Has patient ever been hospitalized? ☐ Yes ☐ No. If yes, what for? _____

Does the patient currently have, or has the patient ever had any of the following?

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Heart Murmur	☐	☐	Congenital Heart Defect	☐	☐	Prosthesis	☐	☐	Scarlet Fever Hx
☐	☐	Cancer	☐	☐	Convulsions/Epilepsy	☐	☐	Asthma	☐	☐	Kidney/Liver Problem
☐	☐	Diabetes	☐	☐	Abnormal Bleeding	☐	☐	Hepatitis	☐	☐	Handicap/Disabilities
☐	☐	Rheumatic Fever	☐	☐	Hearing Impairment	☐	☐	Hemophilia	☐	☐	Any Stays in Hospital
☐	☐	HIV / AIDS	☐	☐	Any Operations	☐	☐	Tuberculosis	☐	☐	Allergy to Any Drugs

Please discuss any serious medical conditions the patient has/had _____

_____

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status.

_____ _____ _____

Print Patient Name Patient Signature Date

For Office Use Only

I verbally reviewed the medical/dental information above with the patient named herein.

_____ _____

Signature Date

_____

Doctor's Comments