

PLEASE COMPLETE THE FRONT
AND BACK OF THIS FORM

Patient Information

A B C

Date _____ Date of Birth _____ Age _____ Sex _____
Patient's Name _____ Home Phone _____
Last First Middle
Address _____
Street City State Zip
Patient's Social Security # _____ School _____ Grade _____
Patient's Dentist _____ Physician _____ Oral Surgeon _____
Names & Ages of Children in Family _____
Whom may we thank for referring you to our office? _____
If patient is a minor, give parent's or guardian's name _____

Responsible Party Information

Name _____
Last First Middle Marital Status
Residence _____
Street City State Zip
Mailing Address _____
Street City State Zip
How long at this address _____ Home Phone _____ Work Phone _____ Cell 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 to Patient _____
Last First Middle
Employer _____ Occupation _____ No. Years Employed _____
Social Security # _____ Birthdate _____ Work Phone _____

Dental Insurance Information

Primary Insured's Name _____ Insured's Soc. Sec. # _____ Insured's Date of Birth _____
Insurance Company _____ Group No. _____ Local No. _____
Insurance Co. Address _____ Ins. Phone # _____
Do you have dual coverage? Yes No If Yes:
Insured's Name _____ Insured's Soc. Sec. # _____ Insured's Date of Birth _____
Insurance Company _____ Group No. _____ Local No. _____
Insurance Co. Address _____ Ins. Phone # _____
Insured's Employer _____

Emergency Information

Name of nearest relative not living with you _____
Complete Address _____
Phone _____

I understand that where appropriate, credit bureau reports may be obtained. I authorize the release of any information as needed for insurance purposes. I hereby authorize payment be made directly from my insurance company to Dr. Chad Smart.
Signature (Parent's signature if minor) _____

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing for your child's dental care. All information will be kept completely confidential.

MEDICAL HISTORY

Physician's Name: _____ Address: _____ Phone: _____

- Has your child experienced any health problems? . . . No Yes Explain: _____
- Any major change in your child's health recently? . . . No Yes Explain: _____
- Is your child currently under physician's care? No Yes Explain: _____
- Is your child currently taking medications? No Yes List: _____
- Is your child allergic to any medications? No Yes List: _____
- Has your child received a blood transfusion? No Yes Reason: _____
- Have your child's tonsils or adenoids been removed? . . No Yes When: _____
- Has your child been in a risk group for AIDS? No Yes Explain: _____

Please check if your child has had any of the following conditions:

- | | | | | | | | | |
|----------------------------------|-----------------------------|------------------------------|--------------------------|-----------------------------|------------------------------|-----------------------------------|-----------------------------|------------------------------|
| Heart Murmur | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Hepatitis | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Emotional Problems | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Heart Surgery | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Diabetes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Frequent Headaches | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Rheumatic Fever | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Kidney Disease | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Nervous/Anxious | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Endocrine Disorders | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Liver Disease | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Cancer | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Prolonged Bleeding | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Tuberculosis | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Bone Disorders | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Anemia | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Bronchitis | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Growth Disorders | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Blood Disease | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Asthma | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Mouth Breather | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Developmental Disorder | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Epilepsy | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Herpes (Fever Blisters) | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Hives/Rash | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Fainting | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Tonsillitis | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

Is there any other condition or problem that you think we should know about? _____

Comments: _____

Growth Information for patients under 16 Years of Age

Because growth can be an important factor in orthodontic treatment planning, your answers to the following questions are needed to aid in our selection of treatment alternatives:

- Has your son or daughter reached puberty? No Yes
- Girls _____ Has she started menstruation? No Yes When? _____
- Boys _____ Has his voice changed? No Yes When? _____
- Height _____ Do you feel growth is completed? No Yes
- Father's Height _____ Mother's Height _____ Adopted? . . No Yes
- Names and Birthdates of patient's brothers and sisters _____
- Have either siblings or parents had orthodontic treatment No Yes With whom: _____

DENTAL HISTORY

Dentist's Name: _____ Address: _____ Phone: _____

- Frequency of dental checkups: Twice a year Once a year Only if a problem exists Never Date of last visit _____
- Is there any unfinished care to be completed with you child's dentist? . . . No Yes Explain: _____
- Is your child frightened about dental treatment? No Yes Explain: _____
- Has your child had an unpleasant experience in a dental office? No Yes Explain: _____
- Has your child had any face or dental injuries No Yes Explain: _____
- Is there any history of thumb or finger sucking? No Yes Stopped?: _____
- Does your child play any musical instrument? No Yes What instrument? _____
- Has your child consulted an orthodontist previously? No Yes With whom? _____
- Have teeth (either primary or permanent) been removed? No Yes
- Has your child had any previous orthodontic treatment? No Yes With whom? _____
- Are you satisfied with prior treatment? No Yes Explain: _____

Please check if there is a history of:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Clenching teeth | <input type="checkbox"/> Muscular soreness around head & neck | <input type="checkbox"/> Jaw joint soreness | <input type="checkbox"/> Jaw joint popping |
| <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Headaches (more than normal) | <input type="checkbox"/> Jaw joint clicking | <input type="checkbox"/> Ringing in the ears |
| <input type="checkbox"/> Speech problems (If so, which sounds _____) | | <input type="checkbox"/> Mouthbreathing: Awake _____ Asleep _____ | |

Is there any other information that may be helpful? _____

Reviewed by: _____ Date _____ Patient's Signature _____