Cranberry Orthodontics ***Please completely fill out the front and back of this sheet***

Patient Information

Last Name ________________________________ First _____________________________Middle ___________________________

Preferred Name ________________________ Sex M ☐ F☐ Birthday _____/_____/___________Age _____________________

Address ____________________________________ City ______________________________ State__________ Zip_____________

Home Phone ________________________Cell Phone ________________________ Email __________________________________

Spouse's Name (if applicable) _______________________________ _School/Employment ________________________________

Siblings/Children (Name and Age) ____

Whom may we thank for recommending our office? ____

Hobbies, activities ____

Responsible Party Information

Last Name ________________________________ First __________________________ Middle ________________ Title _________

Marital Status _________________________ Relationship to Patient ____

Address ______________________________________ City ______________________________ State_________ Zip____________

Home Phone ______________________ Email ____

How long at current address? ______________ Employer ____

Work/Cell Phone _______________________ Occupation ________________________________ Years Employed_______________

Parent/Spouse's Last Name ______________________________First ____________________________Middle _________________

Relationship to Patient _________________________ Employer ____

Occupation ____ Work/Cell Phone ____

Orthodontic Insurance Information

Policyholder's Name ____ Birthday _____/_____/_______

Insurance Company ____

Insurance Co. Address ____ Ins. Co. Phone # ______________________________

Group ____SS/ID Number ____

Signature to authorize payments: ____Dated: _____/_____/__________

Do you have dual coverage? Yes No If Yes:

Policyholder's Name ____ Birthday _____/_____/_______

Insurance Company ____

Insurance Co. Address ____ Ins. Co. Phone # ______________________________

Group ____SS/ID Number ____

Signature to authorize payments: ____Dated: _____/_____/__________

(over)

Dental History

Dentist ____Date of last dental visit _______/_______/__________

What are the main concerns that you would like orthodontics to accomplish?

____

Have you ever had or been evaluated for orthodontic treatment? Yes _______No _______Orthodontist______________________

Have you ever had a serious/difficult problem with previous dental work? Yes _______ No ________

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? Yes _______No _______

Do your gums ever bleed? Yes ________No _______ Problems with Canker/cold sores? Yes _______ No _______

Have you ever had an injury to your Mouth Teeth Chin (please circle and explain) ___________________________________

Do you have any speech problems? ____

Do you generally breathe through your mouth? Day _______ Night _______

Are you aware of any missing permanent teeth? Yes _______ No _______ Extra teeth? Yes _______No ________

Do you require antibiotic premedication prior to any dental procedures? Y N

Habits (please circle yes or no)

Y N Thumb or Finger Sucking

Y N Nail Biting

Y N Grinding Teeth

Please list close relatives who have experienced:

Orthodontic treatment ____

Abnormal jaw growth ____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence a. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature ____ Date ______/______/____________

Thank You!

Cranberry Orthodontics

Please completely fill out the front of this sheet

Patient's Name ____

Medical History

Physician's Name ____

Your current physical health is Good _______ Fair _______ Poor ______

Are you currently under the care of a physician? Yes ______ No ______

If yes, please explain ____

For women: Are you pregnant? ___________ Nursing? ____________

Have you ever had any of the following diseases or medical problems? (*Please circle yes or no*)

Y N Artificial Bones / Joints / Valves

Y N Asthma

Y N Bleeding Problems

Y N Cancer / Chemotherapy

Y N Congenital Heart Defect

Y N Diabetes

Y N Drug / Alcohol Dependency

Y N Emotional Problems

Y N Epilepsy / Seizures / Fainting

Y N Heart Murmur

Y N Hepatitis

Y N High / Low Blood Pressure

Y N HIV+ / AIDS

Y N Hospitalized (Date & Reason): ____________________

Y N Mitral Valve Prolapse

Y N Radiation Treatment

Y N Rheumatic / Scarlet Fever

Y N Severe / Freq. Headaches

Y N Sinus Problems

Y N Smoke or Chewing Tobacco

Y N Tuberculosis (TB)

Y N Venereal Disease

List all medications (or write none) that you are currently taking (prescription and non-prescription) and for what reason

____

Please list any serious medical condition(s) that you presently have or have had in the past (or write none)

____

Please list all allergies including drugs, foods, or materials (or write none)

____

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

Please sign the first line, the additional lines are for yearly updates. (Please do not sign all of the signature lines at this time)

Signature _______________________________________Dr. initial____________ Date: ______/______/____________

Signature _______________________________________Dr. initial____________ Date: ______/______/____________

Signature _______________________________________Dr. initial____________ Date: ______/______/____________

Signature _______________________________________Dr. initial____________ Date: ______/______/____________

Thank You!