POOLE & WILLIS ORTHODONTICS

Confidential Patient Information

Date ____________

Patient's Name ____________ Birthdate ____________ Gender ____________

Address ____________

Home Phone ____________ Cell Phone ____________ Email ____________

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

Name and ages of siblings ____________

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

Confidential Responsible Party Information

A B C

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 ____________

Previous Address (if less than 3 yrs.) ____________ Cell Phone ____________ Email ____________

Social Security # ____________ Birthdate ____________ Relationship to Patient ____________

Employer ____________ Occupation ____________ No. Years Employed ____________

Additional Responsible (or)
Spouse's Name ____________ Relationship to Patient ____________

Address ____________ Home Phone ____________ Cell Phone ____________ Email ____________

Employer ____________ Occupation ____________ No. Years Employed ____________

Social Security # ____________ Birthdate ____________ Work Phone ____________

Insurance Information

Policy Holder's Name ____________ /DOB ____________ ID# ____________ Soc. Sec# ____________

Insurance Company ____________ Group No. ____________

Insurance Co. Address ____________ Insurance Co. Phone ____________

Policy Holder's Employer ____________

Do you have dual coverage? No ☐ Yes ☐ If yes:

Policy Holder's Name ____________ /DOB ____________ ID# ____________ Soc. Sec# ____________

Insurance Company ____________ Group No. ____________

Insurance Co. Address ____________ Insurance Co. Phone ____________

Policy Holder's Employer ____________

Emergency Information

Name of nearest relative not living with you ____________ Relationship ____________

Complete Address ____________ Phone ____________

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

Signature (Parent's signature if minor) ____________

Updates (date & initial) ____________

A B C a b c

Patient's Name ____________________

MEDICAL HISTORY (Circle yes or no and fill in the blanks where required)

1. Is the patient in good health? .... Yes No
2. Has patient reached puberty? .... Yes No
3. Are height and weight normal for age? .... Yes No
4. Have tonsils and/or adenoids been removed? At what age? ________ .... Yes No
5. Frequent colds, sore throats, or ear infections? .... Yes No
6. Any history or major illness? If yes, list ____________________ Yes No
7. Any allergies or drug sensitivity? If yes, list ____________________ Yes No
8. Taking medication now? If yes, list ____________________ Yes No
9. Under medical care now? Reason ____________________ Yes No
10. Circle any of the following for which the patient has been treated:

Hepatitis	Convulsions	Emotional Problems	Fainting	Kidney
Diabetes	Asthma	Prolonged Bleeding	Tonsillitis	Urinary Tract
Arthritis	Epilepsy	Nervous Disorders	Brain Injury	Glaucoma
Heart Trouble	Rheumatic Fever	Endocrine Problems	Tuberculosis	

11. Does the patient have any special problems not listed above? .... Yes No

    If yes, explain: ____________________

DENTAL HISTORY (Circle answer)

1. What are you and your dentist most concerned about? ____________________
   ____
2. Date of last dental exam ____________ Patient's Dentist ____________
3. Have there been any injuries to the face, mouth, or teeth? .... Yes No
4. Has the patient ever sucked their thumbs or fingers? Until what age? .... Yes No
5. Has patient ever had oral habits, such as lip biting or tongue thrusting? .... Yes No
6. Does patient have any speech problems? .... Yes No
7. Has patient ever had any speech therapy? .... Yes No
8. Is the patient a mouth breather while asleep or awake? .... Yes No
9. Are you aware of any missing or extra permanent teeth? .... Yes No
10. Has anyone in the family had orthodontic treatment? .... Yes No
11. Would you consider the patient's diet high in sweets? .... Yes No
12. List any musical instruments played ____________ How long? ________
13. Other Comments: ____________________
14. Has this patient had any orthodontic treatment performed previously? .... Yes No

    If yes, please indicate type and extent of the treatment ____________________
    ____

    Person filling out this form ____________ Relationship to patient ____________

RELEASE AND WAIVER

I authorize release of any information regarding this patient's orthodontic treatment to my dental and/or medical insurance company.

Signature: ____________________ Date: ____________

I have read the above questions and understand them. 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. I will notify my orthodontist of any changes in medical or dental health.

Signature: ____________________ Date: ____________