604 Crandon Blvd. Ste. 205
Key Biscayne Fl, 33149
Phone: 305.361.8695
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PATIENT INFORMATION

Today's Date: ______________________________

Patient's Name: ____ Birthdate: __________________ Age: ______

If patient is a minor, provide parent/guardian's name: ____

Mailing Address: ____

Home Phone: _________________________________ Work Phone:____

Cell Phone: ___________________________________Email address: ____

Patient's School/Employer: ____________________________Grade/Dept: ____

Hobbies/Sports/Musical Instruments: ____

Patient's Dentist: ____________________________________ Referred by:____

RESPONSIBLE BILLING PARTY INFORMATION

Name: ____ Marital Status: ______________________________

Mailing Address: ____

Home Phone: ___________________ Work Phone: ______________________ Cell Phone: ___________________________

Relationship to patient: ____________ Birthdate: _______________________ Social Security #: _______________________

Employer: ____ Occupation: _______________________________________

Spouse's Name: ________________________________ Work or Cell Phone: ______________________________________

Relationship to patient: ____ Social Security #: _______________________

Employer: ____ Occupation: _______________________________________

INSURANCE INFORMATION

Insured's Name: _______________________________ Insured's Member ID #: ____________________________________

Insurance Company: ____Phone #: ____________________________________

Insurance Company Address:____

Insured's Employer: ____________________________________ Group #: ____

Do you have secondary insurance coverage? Yes or No   If Yes, please fill out the following section:

Insured's Name: _______________________________ Insured's Member ID #: ____________________________________

Insurance Company: ____ Phone #: ____________________________________

Insurance Company Address: ____

Insured's Employer: ____________________________________ Group #: ____

EMERGENCY CONTACT INFORMATION

Name of nearest relative not living with you: ______________________________

Address: ______________________________

Phone: ____________________ Relationship to patient: ____________________

MEDICAL HISTORY OF PATIENT

Is the patient in good health? ____________________ YES NO

Has there been any history of asthma, blood disorders, breathing problems, cancer, diabetes, epilepsy, heart problems, HIV/AIDS, joint swelling, kidney ailments, liver ailments, sensation or emotional difficulties, TB, or other illness?_ ___ YES NO

If so, please describe ______________________________

Are you currently under the care of a physician? ____________________ YES NO

Do you currently take any medications? If yes, list: ____________________ YES NO

Are there any allergies? (Latex, nickel, acrylic, medications) ____________________ YES NO

Have you had any major surgeries or hospitalizations? ____________________ YES NO

Do you bleed easily, or is bleeding hard to stop? ____________________ YES NO

Have you experienced any pain or clicking around the jaw joints? ____________________ YES NO

Do you suffer from frequent headaches? ____________________ YES NO

Women: Are you pregnant or nursing? ____________________ YES NO

DENTAL HISTORY OF PATIENT

Approximate date of last dental visit: ____________________ Date of last x-rays: ____________________

Have there been many cavities in the past? ____________________ YES NO

Did any teeth abscess or cause gum boils? ____________________ YES NO

Do your gums bleed easily when you brush or floss? ____________________ YES NO

Any serious problems associated with previous dental treatment? ____________________ YES NO

Have there been any injuries to the teeth? (Chips, falls, blows, etc) ____________________ YES NO

Have any teeth been removed by extraction? ____________________ YES NO

Was it suggested that the space be maintained?____________________ YES NO

Was an appliance placed? ____________________ YES NO

Do you breathe mainly through the mouth (are the lips usually parted)? ____________________ YES NO

Have you ever had a habit of thumb/finger sucking, tongue thrust, or lip biting? ____________________ YES NO

Have you noticed any speech problems? ____________________ YES NO

Have you noticed any difficulty chewing food? ____________________ YES NO

Are you aware of grinding or clenching your teeth? ____________________ YES NO

Are you aware of any missing or extra teeth? ____________________ YES NO

Are you dissatisfied with the appearance of your teeth or other facial structures? ____________________ YES NO

Are you sensitive regarding statements concerning your facial/teeth appearance? ____________________ YES NO

Has the patient seen an orthodontist before? ____________________ YES NO

If so, please describe ____

Has anyone in the family had orthodontic treatment? ____ YES NO

If so, please describe ____

What are the concerns that you would like orthodontics to address? ____

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I understand that the information that I have given is correct to the best of my knowledge and that it will be held in the strictest confidence. I understand it is my responsibility to inform this office of any changes in the patient's medical and dental status. I authorize the orthodontic staff to take dental radiographs, study models, or photos deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.

Patient/Parent/Guardian Signature:

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