

Sean A. Smith, D.D.S.

Orthodontist

Patient Information

Regular Family Dentist: Date: Whom may we thank for referring you to our office?

Name: Nickname: Gender:

Address: City: State: Zip:

Phone: Cell: Work: Birthday:

School: Grade: Employer:

Occupation: Number YRS employed: E-mail Address:

Who should we contact in case of emergency?

Name: Phone: Relationship:

Insurance Information

Who will be financially responsible for treatment? Dental Insurance:

Subscriber: Subscriber ID#:

For Minors

Mother's Name: <input type="text"/>	Birthday: <input type="text"/>	Father's Name: <input type="text"/>	Birthday: <input type="text"/>		
Address: <input type="text"/>		Address: <input type="text"/>			
City: <input type="text"/>	State: <input type="text"/>	Zip: <input type="text"/>	City: <input type="text"/>	State: <input type="text"/>	Zip: <input type="text"/>
Phone: <input type="text"/>	Employer: <input type="text"/>	Phone: <input type="text"/>	Employer: <input type="text"/>		
Cell: <input type="text"/>	Work: <input type="text"/>	Cell: <input type="text"/>	Work: <input type="text"/>		
Occupation: <input type="text"/>	Number YRS employed: <input type="text"/>	Occupation: <input type="text"/>	Number YRS employed: <input type="text"/>		

Patient History

Please check if you have any of the following:

Medical History:

Anemia
Hepatitis
Kidney Problems
AIDS/HIV+
Rheumatic Fever
Heart Disease
Heart Murmur
Stroke
Tuberculosis
Diabetes
Endocrine Problems
Epilepsy
Psychiatric Care
Cleft Lip/Palate
Bone Disorders

Tonsillitis/Adenitis
Tonsils Removed
Adenoids Removed
Asthma
Mouth Breathing
Speech/Hearing Problems
High/Low Blood Pressure
Drug Sensitivity
Neurological Problems
Radiation Treatment
Venereal Disease
Pregnancy
Ulcer or Colitis
Latex Allergy

Dental History:

Head/Face Injuries
Dental Injuries
Thumb/Finger Sucking
Cheek/Lip/Nail Biting
Difficult Oral Surgery
Cinch/Grind Teeth
Click/Pop of Jaw Joint
Jaw Pain
Pain around Ear
Frequent Headaches
Bleeding Gums
Sensitive Teeth
Frequent Cold Sores
Periodontal Treatment
Cigarette/Pipe Smoking

Describe any current medical treatment including drugs taken, even though not listed above:

YES NO

Has the patient ever been treated in an emergency room? If so, why?

Has the patient ever had any unfavorable reactions or allergic reactions to any medication? Describe:

Does the patient presently take any daily medication? Describe:

Physician's Name:

Phone Number:

Is the patient currently under the care of a physician for a current condition? Describe:

Is the patient concerned about the appearance of his/her teeth?

Does the patient play a musical instrument?

Has the patient had previous orthodontic consultation and/or treatment?

Has any member of the family had any orthodontic treatment?

Are you aware that some appointments will infringe on school and/or work time?

GIRLS: Has the patient started her monthly period? If so, what age?

BOYS: Has the patient's voice changed? If so, what age?

Missed or frequently rescheduled appointments are the #1 cause of extending the total treatment time. They also may reduce the success of your treatment. Arriving late for appointments will not permit us to accomplish the treatment we had planned for that day. If you are late for an appointment, you will be rescheduled. If it is necessary to change an appointment we appreciate being notified as far in advance as possible or within 24 hours of your scheduled time. INITIAL:

Signature (parent's signature if patient is a minor)

Date: