



Thank you for providing this important information to help us serve you best. If you have any questions or need assistance, just ask. We're happy to help!

Patient Information

NAME _____ PREFERRED NAME _____ M F

BIRTHDATE _____ AGE _____ GRADE _____ SCHOOL ATTENDS _____

HOME PHONE _____ CELL PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

NAME/RELATIONSHIP OF PERSON ACCOMPANYING PATIENT TO TODAY'S APPOINTMENT _____

PATIENT LIVES WITH WHOM/RELATIONSHIP _____

WHO HAS LEGAL CUSTODY OF PATIENT? _____

NAME OF SIBLINGS & AGES _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

Responsible Party

MARRIED SEPARATED DIVORCED WIDOWED SINGLE

MOTHER'S NAME _____ FATHER'S NAME _____

PARENT GUARDIAN STEPMOTHER PARENT GUARDIAN STEPFATHER

DATE OF BIRTH _____ SSN _____ DATE OF BIRTH _____ SSN _____

ADDRESS _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____ CITY _____ STATE _____ ZIP _____

HOW LONG AT THIS ADDRESS? _____ HOW LONG AT THIS ADDRESS? _____

CELL PHONE _____ CELL PHONE _____

WORK PHONE _____ WORK PHONE _____

EMPLOYER _____ YEARS EMPLOYED _____ EMPLOYER _____ YEARS EMPLOYED _____

OCCUPATION _____ OCCUPATION _____

EMAIL _____ EMAIL _____

Primary Insurance Information

CHECK HERE IF NO ORTHODONTIC COVERAGE WILL BE APPLIED

INSURANCE COMPANY _____ INSURANCE PHONE NUMBER _____

EMPLOYER/GROUP NAME _____ GROUP NUMBER _____

SUBSCRIBER/EMPLOYEE _____ SUBSCRIBER ID/SSN _____

DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

Secondary Insurance Information

CHECK HERE IF NO SECONDARY INSURANCE

INSURANCE COMPANY _____ INSURANCE PHONE NUMBER _____

EMPLOYER/GROUP NAME _____ GROUP NUMBER _____

SUBSCRIBER/EMPLOYEE _____ SUBSCRIBER ID/SSN _____

DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

Emergency Contact Information (OTHER THAN RESPONSIBLE PARTY)

NAME _____ RELATIONSHIP TO PATIENT _____

HOME PHONE _____ CELL PHONE _____

Please take a moment to complete the reverse side of this form.

PLEASE READ: We are passionate about our mission to give everyone a great smile. Please help us help you and your child by letting us know of any delayed development, social disabilities, ADD or ADHD, Bipolar, Autism, etc. _____

Medical History

PHYSICIAN _____ PHONE _____ DATE OF LAST EXAM _____

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|-----------------------------|--------------------------|----------|--------------------------|------------|--------------------------|----------------------|--------------------------|-----------|--------------------------|--------|--------------------------|-------------------|--------------------------|--------|--------------------------|-----------------|--------------------------|---------------------------|--------------------------|-----------------------|--------------------------|--------------------|--------------------------|-------------------|--------------------------|-------------------------|--------------------------|------------------|--------------------------|----------------|--------------------------|-------------------|--------------------------|--------|--------------------------|-----------------|--------------------------|-------------------|--------------------------|-------------------------|--------------------------|----------------------|--------------------------|---------------|--------------------------|---------------|--------------------------|----------------------|--------------------------|-------------------------|--------------------------|--------------------|--------------------------|-----------------------------|--------------------------|
| <p>1. ARE YOU UNDER MEDICAL TREATMENT NOW? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>2. HAVE YOU BEEN HOSPITALIZED FOR ANY SURGICAL OPERATIONS OR SERIOUS ILLNESS IN THE PAST FIVE YEARS? <input type="checkbox"/> <input type="checkbox"/></p> <p>_____</p> <p>3. ARE YOU TAKING MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE? <input type="checkbox"/> <input type="checkbox"/></p> <p>IF YES, WHAT MEDICATION(S) ARE YOU TAKING?</p> <p>_____</p> <p>4. DO YOU USE TOBACCO? <input type="checkbox"/> <input type="checkbox"/></p> <p>5. ARE YOU AWARE OF BEING ALLERGIC TO ANY MEDICATIONS OR SUBSTANCE, INCLUDING METALS? <input type="checkbox"/> <input type="checkbox"/></p> <p>IF YES, WHAT?</p> <p>_____</p> <p>6. FEMALES ONLY: <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>A. HAS MENSTRUATION BEGUN? IF YES, DATE: _____ <input type="checkbox"/> <input type="checkbox"/></p> <p>B. ARE YOU PREGNANT, OR THINK YOU MAY BE? <input type="checkbox"/> <input type="checkbox"/></p> | <p>7. EVER TAKEN BISPHOSPHONATES (EX: FOSAMAX) FOR OSTEOPOROSIS? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>IF YES, SPECIFY _____ <input type="checkbox"/> <input type="checkbox"/></p> <p>8. HAS THE PATIENT REACHED PUBERTY? <input type="checkbox"/> <input type="checkbox"/></p> <p>9. PLEASE CHECK ALL THAT APPLY:</p> <table border="0"> <tr> <td>HAY FEVER/ALLERGIES</td> <td><input type="checkbox"/></td> <td>LEUKEMIA</td> <td><input type="checkbox"/></td> </tr> <tr> <td>COLD SORES</td> <td><input type="checkbox"/></td> <td>KIDNEY/LIVER DISEASE</td> <td><input type="checkbox"/></td> </tr> <tr> <td>MIGRAINES</td> <td><input type="checkbox"/></td> <td>ANEMIA</td> <td><input type="checkbox"/></td> </tr> <tr> <td>DIABETES/GLAUCOMA</td> <td><input type="checkbox"/></td> <td>CANCER</td> <td><input type="checkbox"/></td> </tr> <tr> <td>RHEUMATIC FEVER</td> <td><input type="checkbox"/></td> <td>JOINT REPLACEMENT/IMPLANT</td> <td><input type="checkbox"/></td> </tr> <tr> <td>AIDS OR HIV INFECTION</td> <td><input type="checkbox"/></td> <td>HEPATITIS/JAUNDICE</td> <td><input type="checkbox"/></td> </tr> <tr> <td>CARDIAC PACEMAKER</td> <td><input type="checkbox"/></td> <td>STOMACH TROUBLES/ULCERS</td> <td><input type="checkbox"/></td> </tr> <tr> <td>ASTHMA (INHALER)</td> <td><input type="checkbox"/></td> <td>SINUS PROBLEMS</td> <td><input type="checkbox"/></td> </tr> <tr> <td>FAINTING/SEIZURES</td> <td><input type="checkbox"/></td> <td>STROKE</td> <td><input type="checkbox"/></td> </tr> <tr> <td>THYROID PROBLEM</td> <td><input type="checkbox"/></td> <td>RADIATION THERAPY</td> <td><input type="checkbox"/></td> </tr> <tr> <td>HIGH/LOW BLOOD PRESSURE</td> <td><input type="checkbox"/></td> <td>RESPIRATORY PROBLEMS</td> <td><input type="checkbox"/></td> </tr> <tr> <td>HEART TROUBLE</td> <td><input type="checkbox"/></td> <td>BONE DISORDER</td> <td><input type="checkbox"/></td> </tr> <tr> <td>EPILEPSY/CONVULSIONS</td> <td><input type="checkbox"/></td> <td>OSTEOPENIA/OSTEOPOROSIS</td> <td><input type="checkbox"/></td> </tr> <tr> <td>TAKING MEDICATION:</td> <td><input type="checkbox"/></td> <td>REMOVAL OF ADENOIDS/TONSILS</td> <td><input type="checkbox"/></td> </tr> </table> <p>IF SO, SPECIFY: _____</p> | HAY FEVER/ALLERGIES | <input type="checkbox"/> | LEUKEMIA | <input type="checkbox"/> | COLD SORES | <input type="checkbox"/> | KIDNEY/LIVER DISEASE | <input type="checkbox"/> | MIGRAINES | <input type="checkbox"/> | ANEMIA | <input type="checkbox"/> | DIABETES/GLAUCOMA | <input type="checkbox"/> | CANCER | <input type="checkbox"/> | RHEUMATIC FEVER | <input type="checkbox"/> | JOINT REPLACEMENT/IMPLANT | <input type="checkbox"/> | AIDS OR HIV INFECTION | <input type="checkbox"/> | HEPATITIS/JAUNDICE | <input type="checkbox"/> | CARDIAC PACEMAKER | <input type="checkbox"/> | STOMACH TROUBLES/ULCERS | <input type="checkbox"/> | ASTHMA (INHALER) | <input type="checkbox"/> | SINUS PROBLEMS | <input type="checkbox"/> | FAINTING/SEIZURES | <input type="checkbox"/> | STROKE | <input type="checkbox"/> | THYROID PROBLEM | <input type="checkbox"/> | RADIATION THERAPY | <input type="checkbox"/> | HIGH/LOW BLOOD PRESSURE | <input type="checkbox"/> | RESPIRATORY PROBLEMS | <input type="checkbox"/> | HEART TROUBLE | <input type="checkbox"/> | BONE DISORDER | <input type="checkbox"/> | EPILEPSY/CONVULSIONS | <input type="checkbox"/> | OSTEOPENIA/OSTEOPOROSIS | <input type="checkbox"/> | TAKING MEDICATION: | <input type="checkbox"/> | REMOVAL OF ADENOIDS/TONSILS | <input type="checkbox"/> |
| HAY FEVER/ALLERGIES | <input type="checkbox"/> | LEUKEMIA | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| COLD SORES | <input type="checkbox"/> | KIDNEY/LIVER DISEASE | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MIGRAINES | <input type="checkbox"/> | ANEMIA | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DIABETES/GLAUCOMA | <input type="checkbox"/> | CANCER | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| RHEUMATIC FEVER | <input type="checkbox"/> | JOINT REPLACEMENT/IMPLANT | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| AIDS OR HIV INFECTION | <input type="checkbox"/> | HEPATITIS/JAUNDICE | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CARDIAC PACEMAKER | <input type="checkbox"/> | STOMACH TROUBLES/ULCERS | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ASTHMA (INHALER) | <input type="checkbox"/> | SINUS PROBLEMS | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| FAINTING/SEIZURES | <input type="checkbox"/> | STROKE | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| THYROID PROBLEM | <input type="checkbox"/> | RADIATION THERAPY | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| HIGH/LOW BLOOD PRESSURE | <input type="checkbox"/> | RESPIRATORY PROBLEMS | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| HEART TROUBLE | <input type="checkbox"/> | BONE DISORDER | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EPILEPSY/CONVULSIONS | <input type="checkbox"/> | OSTEOPENIA/OSTEOPOROSIS | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| TAKING MEDICATION: | <input type="checkbox"/> | REMOVAL OF ADENOIDS/TONSILS | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Dental History

DENTIST _____

DATE OF LAST CLEANING _____

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---------------------------------|--------------------------------------|--------------------------|----------|--------------------------|--------------------------|-----------------------------------|--------------------------|--------------------------|---------------------------|--------------------------|--------------------------|---|-----------------|--------------------------|--------------------------|-------------------|--------------------------|--------------------------|------------------------------------|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|----------|--------------------------|---------------|--------------------------|-------------|--------------------------|-----------------------|--------------------------|-------------------------|--------------------------|--------------------------------------|--------------------------|--------------|--------------------------|--------------|--|------------------------|--------------------------|--|--|
| <p>1. ARE YOU ANXIOUS OR NERVOUS ABOUT DENTAL TREATMENT? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>2. DO YOU REQUIRE PREMEDICATION FOR DENTAL TREATMENT? <input type="checkbox"/> <input type="checkbox"/></p> <p>3. DO YOU FEEL PAIN TO ANY OF YOUR TEETH? <input type="checkbox"/> <input type="checkbox"/></p> <p>4. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH? <input type="checkbox"/> <input type="checkbox"/></p> <p>5. HAVE YOU HAD ANY HEAD, NECK, OR JAW INJURIES? <input type="checkbox"/> <input type="checkbox"/></p> <p>IF YES, PLEASE DESCRIBE:</p> <p>_____</p> <p>6. DO YOU HAVE ANY ONGOING PROBLEMS IN YOUR JAW WITH:</p> <table border="0"> <tr> <td>A. CHRONIC CLICKING OR POPPING?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>B. PAIN?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>C. DIFFICULTY OPENING OR CLOSING?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>D. DIFFICULTY IN CHEWING?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table> <p>7. DO YOU CLENCH OR GRIND YOUR TEETH? <input type="checkbox"/> <input type="checkbox"/></p> <p>8. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY? <input type="checkbox"/> <input type="checkbox"/></p> <p>9. HAVE YOU EVER HAD SPEECH THERAPY? <input type="checkbox"/> <input type="checkbox"/></p> <p>IF YES, PLEASE DESCRIBE:</p> <p>_____</p> | A. CHRONIC CLICKING OR POPPING? | <input type="checkbox"/> | <input type="checkbox"/> | B. PAIN? | <input type="checkbox"/> | <input type="checkbox"/> | C. DIFFICULTY OPENING OR CLOSING? | <input type="checkbox"/> | <input type="checkbox"/> | D. DIFFICULTY IN CHEWING? | <input type="checkbox"/> | <input type="checkbox"/> | <p>10. IS THERE ANY OUTSTANDING DENTAL TREATMENT TO BE COMPLETED? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>IF YES, PLEASE DESCRIBE:</p> <p>_____</p> <p>11. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING AND FLOSSING YOUR TEETH? <input type="checkbox"/> <input type="checkbox"/></p> <p>12. DO YOU HAVE ANY OF THE FOLLOWING ORAL HABITS:</p> <table border="0"> <tr> <td>A. NAIL BITING?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>B. THUMB SUCKING?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>C. TONGUE THRUST WHILE SWALLOWING?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>D. MOUTH BREATHING?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table> <p>13. HOW MANY TIMES A DAY DO YOU BRUSH? _____</p> <p>14. PLEASE CHECK THE BOXES BELOW WHICH DESCRIBE THE PROBLEM(S) FOR WHICH YOU ARE SEEKING TREATMENT:</p> <table border="0"> <tr> <td>CROWDING</td> <td><input type="checkbox"/></td> <td>MISSING TEETH</td> <td><input type="checkbox"/></td> </tr> <tr> <td>EXTRA SPACE</td> <td><input type="checkbox"/></td> <td>EXTRA PERMANENT TEETH</td> <td><input type="checkbox"/></td> </tr> <tr> <td>TEETH STICK OUT TOO FAR</td> <td><input type="checkbox"/></td> <td>TEETH ERUPTING IN THE WRONG POSITION</td> <td><input type="checkbox"/></td> </tr> <tr> <td>TMJ PROBLEMS</td> <td><input type="checkbox"/></td> <td>OTHER: _____</td> <td></td> </tr> <tr> <td>POOR BITE RELATIONSHIP</td> <td><input type="checkbox"/></td> <td></td> <td></td> </tr> </table> <p>15. HAS THE PATIENT HAD AN ORTHODONTIC EVALUATION OR TREATMENT BEFORE? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>IF SO, WHEN AND BY WHOM?</p> <p>_____</p> | A. NAIL BITING? | <input type="checkbox"/> | <input type="checkbox"/> | B. THUMB SUCKING? | <input type="checkbox"/> | <input type="checkbox"/> | C. TONGUE THRUST WHILE SWALLOWING? | <input type="checkbox"/> | <input type="checkbox"/> | D. MOUTH BREATHING? | <input type="checkbox"/> | <input type="checkbox"/> | CROWDING | <input type="checkbox"/> | MISSING TEETH | <input type="checkbox"/> | EXTRA SPACE | <input type="checkbox"/> | EXTRA PERMANENT TEETH | <input type="checkbox"/> | TEETH STICK OUT TOO FAR | <input type="checkbox"/> | TEETH ERUPTING IN THE WRONG POSITION | <input type="checkbox"/> | TMJ PROBLEMS | <input type="checkbox"/> | OTHER: _____ | | POOR BITE RELATIONSHIP | <input type="checkbox"/> | | |
| A. CHRONIC CLICKING OR POPPING? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| B. PAIN? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| C. DIFFICULTY OPENING OR CLOSING? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| D. DIFFICULTY IN CHEWING? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| A. NAIL BITING? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| B. THUMB SUCKING? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| C. TONGUE THRUST WHILE SWALLOWING? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| D. MOUTH BREATHING? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CROWDING | <input type="checkbox"/> | MISSING TEETH | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EXTRA SPACE | <input type="checkbox"/> | EXTRA PERMANENT TEETH | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| TEETH STICK OUT TOO FAR | <input type="checkbox"/> | TEETH ERUPTING IN THE WRONG POSITION | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| TMJ PROBLEMS | <input type="checkbox"/> | OTHER: _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| POOR BITE RELATIONSHIP | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Authorization and Release

TO THE BEST OF MY KNOWLEDGE THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES TO THE PATIENT'S MEDICAL STATUS. I GIVE TAYLOR ORTHODONTICS PERMISSION TO PERFORM THE NECESSARY DENTAL SERVICES THAT THE PATIENT MAY NEED.

PRINT NAME _____

RELATIONSHIP TO PATIENT _____ DATE _____

RESPONSIBLE PARTY SIGNATURE