



PATIENT INFORMATION

Patient's Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_
Address: \_\_\_\_\_
City: \_\_\_\_\_ Zip: \_\_\_\_\_
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ (Parent's or Patient's- please circle one)
Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_
Do you play a musical instrument or sports: [ ] Yes [ ] No If yes, please list: \_\_\_\_\_
Parent/Guardian's name: \_\_\_\_\_ Email: \_\_\_\_\_

BILLING INFORMATION

How would you like us to handle the billing arrangements?
[ ] Bill all amounts due to the responsible party noted below.
[ ] Split amounts due in the following proportions:
\_\_\_\_\_ % to \_\_\_\_\_
\_\_\_\_\_ % to \_\_\_\_\_

For completion by parent or guardian of patients under age 21

RESPONSIBLE PARTY #1 INFORMATION

Name: \_\_\_\_\_
Date of Birth: \_\_\_\_\_
Spouse's Name: \_\_\_\_\_
Relationship to Patient: (please check one)
[ ] Father [ ] Mother [ ] Step Parent
[ ] Grandparent [ ] Guardian [ ] Other, please explain \_\_\_\_\_
Mailing Address: \_\_\_\_\_
City: \_\_\_\_\_ Zip: \_\_\_\_\_
Home Phone: \_\_\_\_\_
Cell Phone: \_\_\_\_\_
Work Phone: \_\_\_\_\_
Email Address: \_\_\_\_\_

RESPONSIBLE PARTY #2 INFORMATION

Name: \_\_\_\_\_
Date of Birth: \_\_\_\_\_
Spouse's Name: \_\_\_\_\_
Relationship to Patient: (please check one)
[ ] Father [ ] Mother [ ] Step Parent
[ ] Grandparent [ ] Guardian [ ] Other, please explain \_\_\_\_\_
Mailing Address: \_\_\_\_\_
City: \_\_\_\_\_ Zip: \_\_\_\_\_
Home Phone: \_\_\_\_\_
Cell Phone: \_\_\_\_\_
Work Phone: \_\_\_\_\_
Email Address: \_\_\_\_\_

DENTAL INSURANCE INFORMATION

Primary Policy Holder's Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_
Insurance Company: \_\_\_\_\_
Subscriber ID #: \_\_\_\_\_ Group #: \_\_\_\_\_
Insurance Company Address: \_\_\_\_\_
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_
Secondary Policy Holder's Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_
Insurance Company: \_\_\_\_\_
Subscriber ID #: \_\_\_\_\_ Group #: \_\_\_\_\_
Insurance Company Address: \_\_\_\_\_
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

**MEDICAL HISTORY**

Primary Care Physician: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Please answer the following questions.

Are you taking any medications?  Yes  No If yes, please list medications: \_\_\_\_\_

Are you allergic to latex or metals?  Yes  No

Do you have a history of major illness?  Yes  No If yes, please explain: \_\_\_\_\_

Have you had any major operations?  Yes  No If yes, please explain: \_\_\_\_\_

Please check any of the medical conditions below that you have had or currently have.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Abnormal bleeding/Hemophilia | <input type="checkbox"/> Hepatitis/Liver Problems | <input type="checkbox"/> Anemia              |
| <input type="checkbox"/> Herpes                       | <input type="checkbox"/> Arthritis                | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Asthma or Hay Fever          | <input type="checkbox"/> HIV/AIDS                 | <input type="checkbox"/> Bone Disorders      |
| <input type="checkbox"/> Kidney Problems              | <input type="checkbox"/> Congenital Heart Defect  | <input type="checkbox"/> Nervous Disorders   |
| <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Rheumatic Fever          | <input type="checkbox"/> Dizziness           |
| <input type="checkbox"/> Prolonged Bleeding           | <input type="checkbox"/> Epilepsy                 | <input type="checkbox"/> Tumor or Cancer     |
| <input type="checkbox"/> Heart Problems               | <input type="checkbox"/> Radiation/Chemotherapy   | <input type="checkbox"/> Heart Murmur        |
| <input type="checkbox"/> Tuberculosis                 |   |  |

Are there any medical conditions that we have not listed that you feel we should be aware of?

\_\_\_\_\_

**FEMALE PATIENTS ONLY**

Are you pregnant?  Yes  No

Has menstruation started?  Yes  No

**DENTAL HISTORY**

Family Dentist: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

**PLEASE ANSWER THE FOLLOWING QUESTIONS:**

What concerns you most about your teeth? \_\_\_\_\_

\_\_\_\_\_

Are you presently in any dental pain?  Yes  No Please Explain: \_\_\_\_\_

Have you ever experienced any unfavorable reaction to dentistry?  Yes  No

Please Explain: \_\_\_\_\_

Have you ever lost or chipped any teeth?  Yes  No Please Explain: \_\_\_\_\_

Have there been any injuries to your face, mouth or teeth?  Yes  No Please Explain: \_\_\_\_\_

Is any part of your mouth sensitive to temperature or pressure?  Yes  No Please Explain: \_\_\_\_\_

Do your gums bleed when you brush?  Yes  No

Are you a mouth breather?  Yes  No

Do you have any type of thumb or tongue habit?  Yes  No Please Explain: \_\_\_\_\_

Have you ever seen an orthodontist?  Yes  No If yes, who and when? \_\_\_\_\_

Would you object to wearing orthodontic appliances (braces) should they be indicated?  Yes  No

Has anyone in your family received orthodontic treatment?  Yes  No

How did they feel about the result of that treatment? \_\_\_\_\_

What is your attitude toward receiving orthodontic treatment? \_\_\_\_\_

Do your teeth or jaw ever feel uncomfortable when you awake in the morning?  Yes  No

Are you aware of your jaw clicking or popping?  Yes  No

Are you aware of clenching your teeth during the day?  Yes  No

Have you ever been told that you grind your teeth?  Yes  No

Do you have "tension" headaches?  Yes  No

Have you ever experienced chronic ringing in your ears (Tinnitus)?  Yes  No

*I hereby understand that accurate completion of this form is essential to effective orthodontic diagnosis and treatment. I give Comella Orthodontics permission to examine and take any photographs and radiographs necessary to completely diagnose and plan the course of treatment. I also give Comella Orthodontics permission to contact my general dentist to request a copy of any Panoramic X-rays which will be required in advance for consultation.*

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_