

Confidential Patient Information

Patient's Name: _____ Gender: M F Patient's Nickname: _____
last first middle
 Address: _____ School: _____ Grade: _____
street city state zip
 Home Phone: _____ Birthdate: _____ Social Security No.: _____
 Whom may we thank for referring you to our office?: _____

Confidential Responsible Party Information

Date _____

Name: _____ Marital Status: _____
last first middle
 Residence: _____ Own: _____ Rent: _____
street city state zip
 Billing Address: _____
street city state zip
 How long at this address: _____ Home Phone: _____ Work Phone: _____
 Cell Phone: _____ Email/Text: _____ May we email or text an appt. reminder? _____
 Previous Address (if less than 3 years): _____
street city state zip
 Social Security No.: _____ Birthdate: _____ Relationship to Patient: _____
 Employer: _____ Occupation: _____ Military Pay Grade: _____ No. Years Employed: _____
 Spouse's Name: _____ Relationship to Patient: _____
last first middle
 Employer: _____ Occupation: _____ Military Pay Grade: _____ No. Years Employed: _____
 Social Security No.: _____ Birthdate: _____ Work Phone: _____
 Cell Phone: _____ Email/Text: _____ May we Email or Text an appt. reminder?: _____

Insurance Information

Policy Holder's Name: _____ D.O.B.: _____ Social Security No.: _____
 Insurance Company: _____ Group No.: _____ ID No.: _____
 Insurance Company Address: _____ Insurance Co. Phone: _____
 Policy Holder's Employer: _____
 Do you have dual coverage?: Yes/No If yes, Policy Holder's Name: _____
 Social Security No.: _____ Insurance Company: _____
 Group No.: _____ ID No.: _____ Insurance Co. Address: _____
 Insurance Co. Phone: _____ Policy Holder's Employer: _____

Emergency Contact Information

Name of Emergency Contact: _____ Relationship: _____
 Address: _____ Phone: _____
street city state zip

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

Parent's/Legal Guardian's Signature: _____

Updates (date & initial): _____ Dr. _____ Tech _____

Youth Patient Dental History Information

What is your main orthodontic problem as you see it? _____

Are you sensitive about the appearance of your teeth or facial features (nose, chin, lips, etc)? _____

Are you interested in Traditional Braces? _____

Have you had an orthodontic consultation? Yes _____ No _____ If yes, when? _____

Has anyone in the family received orthodontic treatment from German Orthodontics? Yes _____ No _____

If yes, who? _____

Name of your current general dentist: _____ How many years? _____

Name of previous general dentist: _____

Frequency of dental checkups? _____ Date of last dental exam: _____

Are there any needed restorations? Yes _____ No _____

Date restorations will be completed? _____

Please check any of the following that apply and explain in the box below

- Are you apprehensive about dental care?
- Have you had any trouble associated with dental treatment?
- Have you had any teeth extracted?
- Have you ever injured or broken any teeth?
- Do you have any discomfort from teeth?
- Do you have any missing teeth?
- Do you have any extra teeth?
- Do you habitually grind or clench teeth?
- Do you receive regular fluoride treatment?
- Do you have discomfort from gums?
- Do you have frequent canker sores?
- Are you aware of any swellings or growths in your mouth?
- Do you breathe with your mouth open or lips parted?
- Have you been referred or are you being treated by a dental specialist?
- Have you had any injuries to your face or mouth?
- Have you had any injuries to either jaw?
- Do you suck on your fingers or thumb?
- Do you chew on other objects such as pens?
- Do you have regular jaw pain?
- Do you have limited jaw movement?
- Do your jaws click or pop?
- Do you have any trouble eating, chewing or swallowing?
- Are you in speech therapy currently?

If you have checked any of the above, please explain:

Youth Patient Medical History Information

Name & Location of Physician: _____ Are You in Good Health: _____
Patient's Height: _____ Weight: _____ Has patient's shoe size changed recently? _____
Date of last physical: _____ Are you presently under the care of a physician for any illness? _____ Please specify below.
Do you have a history of major illness or been hospitalized? _____ Please specify below.
Is there anything you would like to talk to the doctor about in private? _____

Please check any of the following that apply to the patient and explain in the box below

- | | |
|---|---|
| <input type="radio"/> Have you seen a medical specialist? | <input type="radio"/> Are you taking any drugs or medications? |
| <input type="radio"/> Do you have a tendency to catch colds? | <input type="radio"/> Have you ever received Bisphosphonate treatment or other bone building medications? (e.g. Fosamax, Actinol, Boniva) |
| <input type="radio"/> Do you have an allergy to latex? | <input type="radio"/> Do you have gastric reflux? |
| <input type="radio"/> Do you have an allergy to metals? | <input type="radio"/> Are you pregnant or breast feeding? |
| <input type="radio"/> Do you have any drug allergies/sensitivities? | |
| <input type="radio"/> Do you require pre-medications? | |

Please check any of the following for which the patient has been treated and explain in the box below

- | | | |
|---|---|--|
| <input type="radio"/> AIDS/HIV? | <input type="radio"/> Fainting or dizziness? | <input type="radio"/> Nervous disorders? |
| <input type="radio"/> Asthma? | <input type="radio"/> Frequent headaches or neck aches? | <input type="radio"/> Osteoporosis? |
| <input type="radio"/> Arthritis? | <input type="radio"/> Heart trouble (i.e. congenital heart defect, murmurs) | <input type="radio"/> Prolonged bleeding? |
| <input type="radio"/> Artificial joints? | <input type="radio"/> Hepatitis? | <input type="radio"/> Rheumatic Fever? |
| <input type="radio"/> Bone disorders? | <input type="radio"/> Hormone therapy? | <input type="radio"/> Sickle cell anemia? |
| <input type="radio"/> Cancer? | <input type="radio"/> Jaundice? | <input type="radio"/> Sleep Apnea/Snoring? |
| <input type="radio"/> Cerebral palsy? | <input type="radio"/> Kidney problems? | <input type="radio"/> Stomach ulcers? |
| <input type="radio"/> Diabetes? | <input type="radio"/> Liver problems? | <input type="radio"/> Tuberculosis? |
| <input type="radio"/> Emotional problems? | <input type="radio"/> Low/high blood pressure? | <input type="radio"/> Thyroid problems? |
| <input type="radio"/> Endocrine problems? | <input type="radio"/> Multiple sclerosis? | <input type="radio"/> Unusual growth patterns? |

If you have checked any of the above, please explain:

I authorize the release of any necessary dental or medical records to German Orthodontics for this patient. Records may be discussed with other health care providers and/or for educational purposes.

Responsible Person

Dr. _____ Tech _____