

WELCOME TO DAVIS ORTHODONTICS

PATIENT INFORMATION

Patient's name: Birthdate: Age:
Name patient likes to be called: Hm: Cell:
Home Address: City: Prov: Postal:
E-mail (Adult patients): WK# (Adult patients):
Name of school: Who may we thank for referring you to our office?

FATHER/GUARDIAN INFORMATION

Name: Relationship to patient: Marital Status:
(if different) Home Address: City: Prov: Postal:
Hm: Cell: WK #: E-mail:

MOTHER/GUARDIAN INFORMATION

Name: Relationship to patient: Marital Status:
(if different) Home Address: City: Prov: Postal:
Hm: Cell: WK #: E-mail:

INSURANCE INFORMATION

Member's Name on the policy: Birthdate:
Name of Insurance Company:
Employer: Local No:
Group/Policy #: Certificate/Contract #:

Coordination of benefits? YES NO If dual coverage, please complete below

Member's Name on the policy: Birthdate:
Name of Insurance Company:
Employer: Local No:
Group/Policy #: Certificate/Contract #:

MEDICAL and DENTAL HISTORY OF THE PATIENT

- Yes No Pregnant?
Yes No Smoker?
Yes No Patient has history of: Arthritis Diabetes Epilepsy Anemia H.I.V Hepatitis Asthma
Bleeding disorders High Blood Pressure Other major illnesses
Currently under any medical treatment?
Currently taking any medications? List:
Allergies? Including Sulpha, Penicillin, Novocain, Metal, Latex, etc.
Do you carry an EpiPen?
Is there a heart condition?
Is there a tendency to faint or become dizzy?
Are there frequent headaches? How often?
Is there any pain, clicking, and/or popping noises in the jaw?
Are you aware of either clenching or grinding of teeth?
Is there frequent snoring and/or sleep apnea?
Is there any difficulty breathing through the nose?
Any habits: Nail biting Finger or thumb sucking Lip or cheek biting Tongue Thrusting Others:
Are there any speech problems?
Have the tonsils and/or adenoids been removed?
Have there been any injuries to the teeth?

Full name of patient's current Dentist:

Signature (Parent's signature, if minor) Today's Date