A B C D X

alexanderorthodontics
{making generations smile}

Date ______________________

Patient's name ____
Last First Middle Nickname

Address ____
Street City State Zip

Male ☐ Female ☐ Age _______ Birthdate __________________ Social Security# ______________________

School ________________________ Grade _____ Sports/Hobbies ______________________________

PARENT OR GUARDIAN

Mr. Dr. Mrs. Ms. _______________________________________ Married ☐ Separated ☐ Divorced ☐

Father's 1st Name ____________________________ Mother's 1st Name ____________________________

Patient's Dentist ____

Relatives Treated at Alexander Orthodontics ______________________________________

Whom may we thank for referring you to our office? ______________________________________

RESPONSIBLE PARTY INFORMATION

Name ____
Last First Middle Nickname

Residence ____
Street City State Zip

Mailing Address ____
Street City State Zip

How long at this address? ______ Home phone ______________________ Work phone ______________________

Cell/other phone ________________________ Email address ______________________________

Social Security# __________________ Birthdate __________________ Relationship to Patient ____________

Employer ________________________ Occupation ______________ No. years employed ____________

Spouse's Name ______________________________________ Relationship to Patient __________________

Mailing Address ____
Street City State Zip

Employer ________________________ Occupation ______________ No. years employed ________________

Social Security# __________________ Birthdate __________________ Cell Phone ______________________

DENTAL INSURANCE INFORMATION

Insured's Name ______________________ Insured's Social Security # ____________________ D.O.B ____________

Insurance Company ______________________________ Group No. ________________ Local No. ______________

Insurance Co. Address ____ Phone No. ____________________

Do you have dual coverage? Yes ☐ No ☐ *If yes:*

Insured's Name ______________________ Insured's Social Security # ____________________ D.O.B ____________

Insurance Company ______________________________ Group No. ________________ Local No. ______________

Insurance Co. Address ____ Phone No. ____________________

EMERGENCY INFORMATION

Name of nearest relative not living with you ______________________________ Phone ____________________

Complete address ____
Street City State Zip

I have received the privacy policies of Alexander Orthodontics, and I understand that, where appropriate, credit bureau reports may be obtained.

☐ *I decline credit.*

Parent Signature ____

Updates (date & initial) ____

alexanderorthodontics
{making generations smile}

Thank you for completeing this questionaire. These questions help us provide the best orthodontic care.

MEDICAL HISTORY (Please circle either Y for yes or N for no)

Have there been any injuries to the face, mouth or chin? **Y N**
Have adenoids/tonsils been removed? **Y N**
Is the patient currently under the care of a physician? **Y N**
Are the patient's immunizations current? **Y N**
Has puberty begun? **Y N**
Has menstruation begun? **Y N**
Is the patient in a growth spurt? **Y N**
Birth Father's Height ___________
Birth Mother's Height ___________
Please list all drugs the patient is currently taking:
____

Is the patient allergic to: Latex/Metals **Y N**
Nickel **Y N**
Plastic **Y N**

Please list any other allergies:
____

Please describe the patient's physical health:
☐ Good ☐ Fair ☐ Poor

Has the patient experienced the following medical problems?

Abdominal Bleeding	**Y N**	Hearing Impairment	**Y N**
ADD/AHD	**Y N**	Heart Murmur	**Y N**
AIDS/HIV	**Y N**	Hemophilia	**Y N**
Any hospital stays/Operations	**Y N**	Hepatitis	**Y N**
Artificial Bones/Joints/Valves	**Y N**	Kidney Problems	**Y N**
Asthma	**Y N**	Liver Problems	**Y N**
Cancer	**Y N**	Mitral Valve Prolapse	**Y N**
Congenital Heart Defect	**Y N**	Prosthetics	**Y N**
Convulsions	**Y N**	Rheumatic Fever	**Y N**
Diabetes	**Y N**	Scarlet Fever	**Y N**
Handicaps/Disabilities	**Y N**	Tuberculosis (TB)	**Y N**

Please describe any serious medical problems the patient has: ______________________________
____

DENTAL HISTORY

Dentist Name ______________________________ Date of last cleaning ______________

Does the patient require antibiotics before dental treatment? **Y N**
Does the patient have any missing permanent teeth? **Y N**
Does the patient brush his/her teeth daily? **Y N**
Does the patient play a musical instrument? Type: ______________ **Y N**
Has the patient had any pain or tenderness in his/her jaw (TMJ/TMD)? **Y N**
Has the patient had dental surgery? **Y N**
Has the patient had prior orthodontic consultation or treatment? **Y N**

Does the patient have any of the following habits?

Clenching/Grinding Teeth	**Y N**
Lip Sucking/Biting	**Y N**
Mouth Breather	**Y N**
Nail Biting	**Y N**
Nursing Bottle Habits	**Y N**
Speech Problems	**Y N**
Thumb/Finger Sucking	**Y N**
Tongue Thrust	**Y N**

Please explain any other conditions or problems we should be aware of: ______________________
____

Describe the patient's orthodontic problem in your own words: ______________________
____

I certify that I have legal responsibilities for this patient, that the information is accurate, and that I will inform Dr. Alexander's office of any changes to this information.

Signature ______________________________________ Date ______________