A B C

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 _____

Chief reason you are seeking treatment? _____

Patient's Dentist _____ Relatives Treated Here _____

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 _____

Previous Address (If less than 3 years) _____

Social Security# _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. years employed _____

Spouse's Name _____ Relationship to Patient _____

Employer _____ Occupation _____ No. years employed _____

Social Security# _____ Birthdate _____ Work 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) _____

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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 _____