

PATIENT INFORMATION

DATE _____

Name _____ Age _____ Date of Birth _____ Sex _____

Nick Name _____ Referred By _____

Family Dentist _____ Dentist Phone # _____

RESPONSIBLE PARTY INFORMATION

Name _____ Relationship to Patient _____

Home Address _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Spouses Name _____ Relationship to Patient _____

INSURANCE INFORMATION

Primary Insured's Name _____ Date of Birth _____ Social Security # _____

Name of Insurance Company _____ Orthodontic Coverage _____ Yes _____ No _____

Insurance Co. Address _____ Employer _____

Insurance Policy Number _____ Insurance Phone _____ Amount of Benefits _____

Secondary Insurance (if any) _____ Phone _____

Secondary Insurance Address _____

HEALTH HISTORY

Does the patient have or has he/she ever had:

Anemia _____ Y N Heart Murmur _____ Y N Diabetes _____ Y N Heart Problems _____ Y N

Convulsions _____ Y N Rheumatic Fever _____ Y N Hepatitis _____ Y N Bleeding Problems _____ Y N

Asthma _____ Y N Tuberculosis _____ Y N Allergies _____ Y N AIDS / HIV _____ Y N

Other medical problems _____ Allergic to _____

Name of Physician _____ Current Medications _____

DENTAL HISTORY

Current Dental / Orthodontic Concern: _____

Do you have any jaw / joint (TMJ) pain? _____ Y N Have you ever received a blow to teeth or jaw? _____ Y N

Does your jaw pop or click? _____ Y N Do you have any neck pain? _____ Y N

Do you clench or grind your teeth? _____ Y N Do you have severe headaches? _____ Y N

Do you have thumb or finger sucking habit? _____ Y N Do you have any dental discomfort / pain _____ Y N

Approximate date of your last dental check up _____ Other problems _____

I attest that the above information is true and correct and if any of this information changes during the course of care, I will notify Dr. Dau.
I also authorize the dental staff to take photographs, x-rays and perform the necessary dental services my child or I may need.

Signature (Parent or Legal Guardian if under 18) Date