

Patient's Name



Patient Information Sheet
<Please Fill out Completely>

First Appointment:

Prefers to be Called: _____
 Patients Address: _____ Telephone: _____
 Birthdate: _____ Age: _____ Sex: _____
 School/Employer: _____ Grade/Position: _____
 Interest/Sports _____

Primary Mother Father Step Parent Self Other <specify> _____
 If divorced, who is custodial parent? _____ Release of pt info to non-custodial parent OK? Y N
Responsible Party: _____ Telephone: _____
 Address: _____ Cell Number: _____
 Employer/Address: _____ Telephone: _____
 Social Security Number: _____

Secondary Mother Father Step Parent Self Other <specify> _____
Responsible Party: _____ Telephone: _____
 Address: _____ Cell Number: _____
 Employer/Address: _____ Telephone: _____
 Social Security Number: _____ DOB: _____ Email Address: _____

How did you hear about our office? Dentist Patient Relative Acquaintance Other <specify> _____
 Who may we thank for referring you to us? _____ Present Dentist: _____
 In your opinion, what is your orthodontic problem? _____

Circle Yes or No if patient has history Latex or Nickel Allergy: Y N : Antibiotics Required before Dental Procedures? Y N : Pregnant Y N

NO significant ongoing medical problems as listed below (Initial here) _____

Aids	Y N	Cancer	Y N	Endocrine problems	Y N	High Blood Pressure	Y N	Pneumonia	Y N	Tooth Grinding	Y N
Allergies	Y N	Cerebral palsy	Y N	Emotional disorders	Y N	Immune Problems	Y N	Mitral Valve Prolapse	Y N	Tuberculosis	Y N
Anemia	Y N	Chest pains	Y N	Epilepsy	Y N	Kidney Problems	Y N	Prolonged Bleeding	Y N	Venereal Disease	Y N
Arthritis	Y N	Chronic neck pain	Y N	Fainting, Dizziness	Y N	Low Blood Pressure	Y N	Rheumatic Fever	Y N	Herpes	Y N
ADD/ADHD	Y N	Clicking of jaw	Y N	Glaucoma	Y N	Muscular disorders	Y N	Scoliosis	Y N	Removal of Teeth	Y N
Asthma	Y N	Cold Sores	Y N	Headaches	Y N	Nervous Disorders	Y N	Seizures	Y N	Dry Mouth	Y N
Autoimmune	Y N	Diabetes	Y N	Heart condition	Y N	Organ Transplant	Y N	Sensitive Teeth	Y N	Ear problems	Y N
Artificial Joint	Y N	Downs Syndrome	Y N	Hemophilia Type	Y N	Bone disorder	Y N	Speech problems	Y N	Pain in Jaw/Face	Y N
Bulimia	Y N	Drug allergies -list	Y N	Hepatitis Type	Y N	Periodontal problems	Y N	TMJ problems	Y N	Tobacco Use	Y N

Any disease, problems, or allergies/anaphylaxis not mentioned above? _____
 Under care of Physician? _____ Current Medications: _____
 Most Recent Dental Cleaning and Check-up _____ List any oral habits (thumb sucking, etc.) _____
 Have wisdom teeth been extracted? _____ Any face, mouth or teeth injuries? _____
Does patient have dental or periodontal problems requiring treatment? _____ Do gums bleed when brushed or flossed? _____
 Has an orthodontist been consulted previously? _____ Have you had previous orthodontic treatment? _____
 Are there any missing or extra teeth? _____ Have the Tonsils and adenoids been removed? _____
 If required to pre-medicate with antibiotics prior to dental procedures, state for which condition? _____
 Does patient have Brothers / Sisters? _____

Insurance Information (Please fill out completely so we may properly file your insurance)

Name of Primary Orthodontic Insurance: _____ Telephone: _____
 Name of Policy Holder: _____ Mother Father Step Parent Self Other <specify> _____
 Policy Holders Birthdate: _____ Policy ID# or Holder's SSN _____

I understand the info given is correct to the best of my knowledge, that it will be held in strict confidence, and it is my responsibility to inform Dr. Russell of any changes in my (my child's) medical status.
 I hereby authorize the release of medical/dental info to insurance cos. and other healthcare providers involved in this patient's care and the use of records by Dr. Russell for teaching or scientific publication.

Signature: _____ Relationship To Patient: _____ Date: _____

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