Date:

Heritage Orthodontics

Patient Information

Patient's Last Name: | Patients' First Name | Patient Called | Gender M/F

Patient's DOB | Patient's Age | Patient's E-Mail Address | Patient's Social Security #

Patient Street Address | Patient's City, ST Zip | Patient's Home Ph # | Patient's Other Ph #

If patient is a minor:

Last Name Accompanying Adult | First Name Accompanying Adult | Ph # of Accompanying Adult | Relationship to patient

Whom may we thank for referring you to our office? | DDS: | Patient/Friend:

Sibling/Children information:

1. Sibling/Child Full Name | M/F | Sibling/Child DOB | 4. Sibling/Child Full Name | M/F | Sibling/Child DOB

2. Sibling/Child Full Name | M/F | Sibling/Child DOB | 5. Sibling/Child Full Name | M/F | Sibling/Child DOB

Responsible Party Information

Res Party Last Name: | Res Party First Name | Res Party Email Address | # Yrs Current Residence

Res Party Street Address # | Res Party City, ST Zip | Res Party Home Ph # | Res Party Other Ph

Mailing Address or Previous Address if less than 3 yrs at current residence:

Responsible Party Mailing Street Address | Responsible Party Mailing City, ST Zip | Previous Address (If less than 3 Yrs) | Previous City, ST Zip (If less than 3 Yrs)

Res Party Social Security # | Res Party Employer | Res Party Occupation | # Yrs Current Employer | Res Party DOB

Spouse Partner Information:

Spouse/Partner | Relationship to Patient | Occupation | # Yrs Current Employer | Spouse/Partner DOB

Spouse/Partner Social Security # | Spouse/Partner Work Ph # | Spouse/Partner Email Address

Orthodontic Insurance Information

Insured's Last Name: | Insured's First Name | Insurance Co Name | Insured's Group #

Insurance Co St Address | Insurance Co. City, ST Zip | Insurance Co Ph # | Insureds' Employer | Insured's DOB

Secondary Insurance Information:

Insured's Last Name: | Insured's First Name | Insurance Co Name | Insured's Group #

Insurance Co St Address | Insurance Co City, ST Zip | Insurance Co Ph # | Insured's Employer | Insured's DOB

Emergency Information

Em Contact Person | Em Contact St Address | Em Contact City, ST Zip

Em Contact Person Relationship | Em Ph #

To the best of my knowledge all information is correct.
I understand that were appropriate; credit bureau reports may be obtained.

Signature (Parent's signature if minor):

Patient's Dentist | Last Dental Visit

Orthodontic	Dental	Medical
What concerns would you like orthodontics to accomplish?	**Do you need a referral to a Dentist?** ☐ **yes**	**Physician's Name:** **Last physical exam:** - -
Has an orthodontist been previously consulted? ☐ **yes** ☐ **no**	**Is there any dental work that needs to be completed prior to orthodontic treatment?** ☐ **yes** ☐ **no**	**Is patient under the care of a physician at this time?** ☐ **yes** ☐ **no** **If yes, please explain reason for physician's care:**
Indicate the patient's feelings toward orthodontic treatment? ☐ **eager to get started** ☐ **complacent** ☐ **not committed to cooperate**	**Are antibiotics necessary for teeth cleanings?** ☐ **yes** ☐ **no** **Did you know that the AHA recommendations changed as of 2007?** ☐ **yes** ☐ **no**	**List any medications being taken at this time:**
Hobbies/Comments:	**Have you in the past or are you taking "Bisphosphonates" that are prescribed by your physician to treat a variety of illnesses. Examples include Fosamax (alendronate), actonel (risedronate), Boniva (ibandronate), Skelid (tiludronate), Didronel (didronate), Aredia (pamidronate), or Zometa (zoledronic acid).** ☐ **yes** ☐ **no**	**List any drugs/things that patient is allergic to or has a reaction to:**

Please complete patient's medical history information.

Abnormal Bleeding	☐ yes ☐ no	Hemophilia	☐ yes ☐ no
Plastic/Metal Allergy	☐ yes ☐ no	High Blood Pressure	☐ yes ☐ no
Latex Allergy	☐ yes ☐ no	Cavities Now	☐ yes ☐ no
Epilepsy/Convulsions	☐ yes ☐ no	Smoke/Chew Tobacco	☐ yes ☐ no
Thyroid Problems	☐ yes ☐ no	Missing Permanent Teeth	☐ yes ☐ no
Kidney/Liver Problems	☐ yes ☐ no	Clenching or Grinding	☐ yes ☐ no
Heart Murmur	☐ yes ☐ no	Diabetes	☐ yes ☐ no
Finger/Thumb Sucking	☐ yes ☐ no	Asthma	☐ yes ☐ no
Tooth/Jaw Trauma	☐ yes ☐ no	Hepatitis	☐ yes ☐ no
Lip/Tongue Biting	☐ yes ☐ no	Tuberculosis	☐ yes ☐ no
Tonsils/Adenoid Problems	☐ yes ☐ no	Disabilities	☐ yes ☐ no
AIDS/HIV	☐ yes ☐ no	Venereal Disease	☐ yes ☐ no
Heart Problems	☐ yes ☐ no	Mouth Breathing	☐ yes ☐ no
Cancer or Tumor	☐ yes ☐ no	Headaches	☐ yes ☐ no
Fainting or Dizziness	☐ yes ☐ no	Tongue Thrust	☐ yes ☐ no
Pregnant Now	☐ yes ☐ no	Extra Teeth	☐ yes ☐ no

Please explain ANY Disease, Medical or Dental Condition that is not mentioned above:

AFFIRMATION: I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office immediately of any changes in medical status. I grant Periago Orthodontics the right to use my diagnostic information for teaching and learning opportunities and use photos and first names only for social media. *I understand that were appropriate; credit bureau reports may be obtained.*

I grant the right for the following to also review this account information:

Signature (Parent's signature if minor) | Date

I verbally reviewed all medical and dental information above with the patient/parent/guardian names herein.

Date | Updates- Date | Initial