Date____/____/____

CONFIDENTIAL PATIENT INFORMATION

Patient's Name ______________________________ (Last) (First) (Middle)

Address ______________________________

Home Phone ____________ Age ______ Birthday ____________ Social Security # ____________

Employer/School ______________________________ Grade ____________

How did you hear of our office? ____________ Dentist ____________ Physician ____________

Have we seen any other member of your family? If so please list. ______________________________

If patient is a minor with whom does the child reside? ______________________________

CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

Patient or Person
Responsible for Account. ______________________________ (Last) (First) (Middle) Martial Status ____________

Residence ______________________________ (Street) (City) (State) (Zip)

Mailing Address ______________________________ (Street) (City) (State) (Zip)

Home Phone ____________ Work Phone ____________ Cell Phone ____________

How long at this address? ________ Previous Address (if less than 3 yrs.) ______________________________ (Street) (City) (State) (Zip)

Email Address ______________________________

Social Security # ____________ Birthday ____________ Relationship to Patient ____________

Employer ____________ Occupation ____________ No. Years Employed ____________

Responsible Person's Spouse's Name ______________________________ (Last) (First) (Middle) Relationship to Patient ____________

Employer ____________ Occupation ____________ No. Years Employed ____________

Social Security # ____________ Birthday ________ Work Phone ____________ Cell Phone ____________

*All billing will be directed to the custodial parent. It is our office policy not to split accounts for any reason.

INSURANCE INFORMATION

Policy Holder's Name ______________________________ and Social Security # ____________

Insurance Company ______________________________ Group No. ____________ Employer ____________

Insurance Co. Address ______________________________ Insurance Co. Phone # ____________

Do you have dual coverage? Yes ☐ No ☐ If yes please fill out the following:

Policy Holder's Name ______________________________ and Social Security # ____________

Insurance Company ______________________________ Group No. ____________ Employer ____________

Insurance Co. Address ______________________________ Insurance Co. Phone # ____________

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment

______________________________ signed (patient. or parent if minor) ________ Date

I hereby authorize payment directly to the below-named dentist of the group insurance benefits otherwise payable to me.

______________________________ Signed (Insured Person) ________ Date

EMERGENCY INFORMATION

Name of nearest relative/friend not living with you ______________________________

Complete Address ______________________________

Phone ______________________________ Relationship: ______________________________

I also give my approval and consent for my/or my child's name and/or photograph to be used in scientific and/or promotional work produced by Dr. Drake and his staff. I understand that where appropriate, credit bureau reports may be obtained.

PATIENT SIGNATURE (Parent's signature if minor) ______________________________

Updates (date & Initial) ______________________________

~ PLEASE COMPLETE ENTIRE FORM, FRONT AND BACK ~

MEDICAL HISTORY

Is patient in good health? Yes ❑ No ❑ Does patient have any history of major illness: ______________ Yes ❑ No ❑

Has patient ever been under the care of a physician for illness? ______________ Yes ❑ No ❑

Please list: ______________

Check any of the following for which the patient has been treated:

Diabetes ❑	Tuberculosis ❑	Endocrine Problems ❑
Pneumonia ❑	Anemia ❑	Prolonged Bleeding ❑
Heart Trouble ❑	Epilepsy ❑	Fainting or Dizziness ❑
Rheumatic Fever ❑	Asthma ❑	Nervous Disorders ❑
Bone Disorders ❑	Kidney Involvement ❑	Liver Involvement ❑

Does patient have tendency to: Colds ❑ Sore Throats ❑ Ear Infections ❑

Have tonsils and adenoids been removed? What age? ______________ Yes ❑ No ❑

List any drugs or medications now being taken, give reasons: ______________

____

List any allergies or drug sensitivity: ______________

Has the patient reached puberty? Girls – Has she started menstruation ______________ Yes ❑ No ❑

Boys – Has his voice changed ______________ Yes ❑ No ❑

Height ______________ Weight ______________

Hereditary Manifestations: Father's Height ______________ Mother's Height ______________

DENTAL HISTORY

Have there been any injuries to the face, mouth or teeth? ______________ Yes ❑ No ❑

Has the patient ever sucked a thumb or fingers? Until what age? ______________ Yes ❑ No ❑

Does the patient have any speech problems? ______________ Yes ❑ No ❑

Is the patient a mouth breather? While awake? Yes ❑ No ❑ While asleep? Yes ❑ No ❑

Have you been informed of any missing or extra permanent teeth? ______________ Yes ❑ No ❑

Has an orthodontist been consulted previously? Yes ❑ No ❑ Has either parent had orthodontic treatment? Yes ❑ No ❑

Has the patient had previous orthodontic treatment? Yes ❑ No ❑

Name & address of orthodontist: ______________

What were his recommendations? ______________

Names and ages of other children in family: ______________

List any musical instruments played: ______________ Hobbies: ______________

Main concern: ______________

____