		Patient Information Sheet *<Please Fill out Completely>*

First Appointment: @	

Prefers to be Called:					

Patients Address:	,	Telephone:	

Birthdate:		Age:		Sex:		Carrier:	

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:	DOB:	Email Address:

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:	Dr.

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: ~medication~	

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 a family member that cares to be evaluated:	

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:	