Northern smiles orthodontics
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ORTHODONTIC PATIENT INFORMATION - MINOR

A B C

PATIENT

First _____ MI ___ Last _____ Prefers to be called _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Birth Date _____ Male _____ Female _____

School _____ Grade _____

RESPONSIBLE PARTY INFORMATION

First _____ MI ____ Last _____ Birth Date _____

Mailing Address _____ City _____ State _____ Zip _____

How long at this address _____ Home Phone _____Work Phone _____ Cell Phone _____

Previous Address (if less than 3 years) _____ City _____ State _____ Zip _____

Social Security # _____ Marital Status _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Parent's E-mail_____

Spouse's First Name _____ MI _____Last _____Relationship to Patient _____

Spouse's Employer _____ Occupation _____ No. Years Employed _____

Spouse's Social Security # _____ Spouse's Birth Date _____ Phone #_____

OTHER PARENT(S) OR GUARDIAN(S) INFORMATION* ***(If different from above)****

First _____ MI ____ Last _____ Marital Status _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____Work Phone _____ Cell Phone _____Relationship to Patient _____

Birth Date_____ Employer_____ Social Security #_____

INSURANCE INFORMATION ~ ***Primary Insurance Information***

Insured's Name _____ DOB _____ Insured's Social Security # _____

Insurance Company _____Policy/ID# _____Employer_____

Insurance Co. Address _____Ins Co Phone:_____

Do you have dual coverage? ☐Yes ☐No If Yes,

Secondary Insurance Information

Insured's Name _____ DOB _____ Insured's Social Security # _____

Insurance Company _____Policy/ID# _____Employer_____

Insurance Co. Address _____Ins Co Phone:_____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship to Patient _____

Continued on back-→

OTHER INFORMATION

Were you referred to this office ☐Yes ☐No Name of person referring you _____

If you were not referred to this office, how did you hear about us? ☐Internet Ad ☐Website ☐Internet Search ☐Other _____

Has any member of your immediate family received treatment in our office? ☐Yes ☐No If so, Who? _____

MEDICAL HISTORY

Physician's Name _____ Are you in good health? ☐Yes ☐No

Do you have or have you had any of the following diseases or problems?

☐ Rheumatic Fever

☐ Congenital heart problems

☐ Heart murmurs or heart surgeries

☐ Artificial heart valves

☐ Artificial joints

☐ Any condition that requires prophylaxis (antibiotics before dental procedures)

☐ Cardiovascular disease (heart attack, heart trouble, high blood pressure, stroke)

☐ Hepatitis - Type _____

☐ Hemophilia

☐ Diabetes

☐ Epilepsy/Convulsions

☐ Asthma - controlled by _____

☐ Aids or HIV positive

List any other serious recurrent illnesses (physical or mental) _____

Are you or have you ever taken bisphosphonate drugs (such as Boniva, Fosamax, Actonel, etc.) ☐ Yes ☐ No ☐ Oral ☐ IV

Allergic reactions? (Including latex) _____

BOYS: Has your voice changed? ☐ Yes ☐ No GIRLS: Have you begun menstruation? ☐ Yes ☐ No

DENTAL HISTORY

Dentist's Name _____ Date of last cleaning/check-up _____

Have you had any of the following treatment?

☐ Periodontal treatment (gum treatment) How long ago? _____ Describe Treatment: _____

☐Mouth guard or splint - For what purpose? _____☐ Surgery to change your bite_____

Are you aware of any of the following?

☐ Sores, lumps or irritated areas in your mouth

☐ Food catching between your teeth

☐ Clenching or grinding teeth

☐ Sore or bleeding gums

☐ Clicking, popping or grating noise in your jaw ☐Right ☐Left ☐Both sides

☐ Have you had your tonsils/adenoids removed?

☐ Have you been a thumb sucker? If yes, until what age? _____

☐ Have you been a mouth-breather?

☐ Have you been a lisper?

☐ Any unpleasant experiences at a dental office we should know about? If so, let us know.

The information I have given is correct and will be held in the strictest of confidence. I promise to be responsible for any charges that are incurred for the above-mentioned patient, and I authorize Dr. Devin P. Johnson, DMD, MS to evaluate and/or treat this patient.

I understand that where appropriate, soft-inquiry Credit Bureau reports may be obtained.

Signature of Responsible Party_____ ***Date*** _____