



Devin Johnson, DMD, MS
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ORTHODONTIC PATIENT INFORMATION - MINOR

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PATIENT

First MI Last Prefers to be called
Address City State Zip
Home Phone Birth Date Male Female
School Grade
Parent's Marital Status Parent's E-mail

RESPONSIBLE PARTY INFORMATION

First MI Last Birth Date
Residential Address City State Zip
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
Spouse's First Name MI Last Relationship to Patient
Spouse's Employer Occupation No. Years Employed
Spouse's Social Security # Spouse's Birth Date

OTHER PARENT(S) OR GUARDIAN(S) INFORMATION

First MI Last Marital Status
Residential Address City State Zip
Mailing Address City State Zip
Home Phone Work Phone Cell Phone Relationship to Patient

INSURANCE INFORMATION

Primary Insurance Information

Insured's Name DOB Insured's Social Security #
Insurance Company Group #
Insurance Co. Address
Do you have dual coverage? Yes No If Yes,

Secondary Insurance Information

Insured's Name DOB Insured's Social Security #
Insurance Company Group #
Insurance Co. Address

EMERGENCY INFORMATION

Name of nearest relative not living with you
Complete Address
Phone Relationship to Patient

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 _____