CROSSROADS ORTHODONTICS

PATIENT INFORMATION

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____

Date of Birth _____ Email _____

Patient's Dentist _____ School (if applicable)_____

RESPONSIBLE PARTY INFORMATION

Responsible Party #1 _____ _____
Last First Relationship to patient

Address (if different from patient): _____

Home phone _____ Work or Cell _____ Date of Birth _____

Email address:_____ Social Security # _____

Employer _____ Occupation _____

Responsible Party #2 _____ _____
Last First Relationship to patient

Address (if different from patient): _____

Home phone _____ Work or cell _____ Date of Birth _____

Email address:_____ Social Security # _____

Employer _____ Occupation _____

DENTAL INSURANCE INFORMATION

Insured Name: _____ Insured ID # _____

Insurance Company: _____ Group # _____ Phone # _____

Insurance Company address: _____

Do you have dual coverage? YES _____ NO _____ If yes:

Insured Name: _____ Insured ID # _____

Insurance Company: _____ Group # _____ Phone # _____

MEDICAL HISTORY OF PATIENT

Has there been any history of (please circle) joint swelling, heart trouble, asthma, TB, AIDS, kidney or liver condition, epilepsy, rheumatic fever, or other major illness? Please explain.

Does the patient bleed easily, or is bleeding hard to stop?	Y	N
Is there a tendency to faint or become dizzy?	Y	N
Are there any allergies? (latex, sulpha, penicillin, etc)?	Y	N
Have tonsils and/or adenoids been removed?	Y	N
Any history of osteoporosis medication (Fosamax, Boniva, etc)?	Y	N
If yes, what type, duration, IV or oral? _____		
_____		
Are medications now being taken? List: _____	Y	N
_____		
Is the patient under the care of a physician at present?	Y	N

DENTAL HISTORY OF PATIENT

Have there been any injuries to the teeth? (falls, chips, blows)	Y	N
Were any teeth removed by extractions?	Y	N
Was it suggested that the space be maintained after extraction?	Y	N
Was an appliance placed?	Y	N
Were there habits that might have caused the teeth to move?	Y	N
Has the patient had previous orthodontic treatment?	Y	N

TMJ PATIENT HISTORY

Is there any clicking or popping of the joints?	Y	N
Does the patient have frequent headaches or neck pain?	Y	N
Does the patient grind teeth at night?	Y	N
Does the patient have muscle soreness in the face?	Y	N
Has the patient ever had an accident involving the teeth jaw or face?	Y	N

Have we treated any other family members? If yes, who? _____

How did you find out about our practice? _____

- □ Friend/neighbor _____
- □ Delta or Metlife website
- □ Other Please specify _____
- □ Community Event Please specify _____
- □ School Presentation Please specify _____
- □ Dentist _____
- □ Location/walk-in

By signing this, I agree to be responsible for full payment of all fees for the orthodontic services performed on the above mentioned patient.

_____ _____ _____

Signature Relationship Date

ALL INFORMATION IS CONFIDENTIAL