



600 4th St. NE, Suite 103
Watertown, SD 57201

Date _____

PATIENT INFORMATION

Name _____
First Middle Initial Last

Address _____
Street City State / Zip Code

Phone _____
Home Cell Work

Age _____ Birth Date _____ Sex _____ School _____

Whom may we thank for referring you to our office _____

General Dentist _____

Physician _____ Address or Clinic _____

If patient is a minor, give parents or guardian's name _____

RESPONSIBLE PARTY INFORMATION

Father's Name _____ <small>Circle one: father or stepfather or guardian</small>	Mother's Name _____ <small>Circle one: mother or stepmother or guardian</small>
Birth Date _____ SSN _____	Birth Date _____ SSN _____
Address _____	Address _____
City / State / Zip _____	City / State / Zip _____
Phone _____ (home) _____ (cell) _____ (work)	Phone _____ (home) _____ (cell) _____ (work)
Employer _____	Employer _____
Email Address _____	Email Address _____

ORTHODONTIC INSURANCE INFORMATION

Note: We are not a Medicare provider.

Insured's Name _____	ID # or SSN # _____
Relationship to Patient _____	
Insured's Employer _____	Insured's Birth Date _____
Insurance Company _____	Address _____ <small>Street</small>
Group # _____	_____ City / State / Zip
Do you have dual coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete the following:	
Insured's Name _____	ID # or SSN # _____
Relationship to Patient _____	
Insured's Employer _____	Insured's Birth Date _____
Insurance Company _____	Address _____ <small>Street</small>
Group # _____	_____ City / State / Zip

MEDICAL-DENTAL HISTORY

Do you have or have you had any of the following diseases or problems? Please circle the correct answer and complete the questions.

1. Yes No Are you currently taking any medications? Please list:_____
2. Yes No Are you allergic to any medication? Please list:_____
3. Yes No Have you ever had any allergic reactions to latex or other materials? Please list:_____
4. Yes No Rheumatoid or arthritic conditions?
5. Yes No Diabetes?
Yes No Osteoporosis?
6. Yes No Excessive bleeding, black and blue tendency, anemia or bleeding disorder?
7. Yes No Cardiovascular problems (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects or rheumatic heart?)
8. Yes No Hay fever, asthma, sinus trouble, hives?
9. Yes No Fainting spells, seizures, epilepsy or neurological disease?
10. Yes No Do you currently have or ever had a substance abuse problem?
11. Yes No AIDS or HIV positive?
12. Yes No Sexually transmitted disease?
13. Yes No For females – Are you pregnant?
14. Yes No Birth defects or hereditary problems?
15. Yes No Mouth breathing habit, snoring, difficulty in breathing?
16. Yes No Frequent headaches?
17. Yes No Tooth grinding, jaw clenching, locking or clicking of jaw joints?
18. Yes No Do you experience any pain or soreness in the muscles of your face, or around your ears?
19. Yes No Do you have any pain or ringing in the ears?
20. Yes No Have you ever been treated for “TMJ” problems (jaw joint or facial muscle pain)?
Please explain:_____
21. Yes No Have you ever been examined by another orthodontist, had orthodontic treatment or worn a “retainer” or “bite plate”?
Please explain:_____
22. Yes No Has any other family member had orthodontic treatment? _____
In this office?_____
23. Date of most recent dental examination:_____
24. What is your primary concern? Why are you here?_____

25. Realizing that successful treatment greatly depends upon complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment?_____

I certify that the information above is accurate to the best of my knowledge. If there are any changes to this information, I will so inform this practice.

Signature of patient or guardian if patient is a minor.

Date

Thank you for taking the time to complete this questionnaire.

I have reviewed the information entered on this form on _____

Date

Signature of Dentist

MEDICAL HISTORY UPDATE

Date	Comments	Signature
------	----------	-----------

_____	_____	_____
_____	_____	_____
_____	_____	_____