

Patient's Name _____ **Age** _____ **M or F** **Birthdate** _____

Do you have a nickname or other name that you go by, different than the name above? _____

How did you hear of The Brace Place? _____

Who may we thank for referring you to The Brace Place? _____

Reason for Visit _____

Brothers/sisters (names & ages) _____

Address (please include zip) _____

School _____ **Year Graduate** _____ **Cell/Home Phone** _____ **SSN** _____

What is the best email address in case we need to contact you? _____

Mother's Name _____ **Cell/Home Phone** _____

Address (with zip) _____ **SSN** _____

Employed by _____ **Work Phone** _____

Position _____ **How long held** _____

Father's Name _____ **Cell/Home Phone** _____

Address (with zip) _____ **SSN** _____

Employed by _____ **Work Phone** _____

Position _____ **How long held** _____

Who will pay this account? _____

Do you have insurance that covers orthodontics? (circle) **yes no**

If yes provide the insurance company name _____

(Please provide receptionist with insurance card so we can provide a predetermination of benefits)

Subscriber Name _____ **Subscriber SS#** _____ **Subscriber DOB** _____

Dentist's Name _____ **Last dental checkup** _____

Have you ever been prescribed antibiotics before dental procedures? _____

If so, when, and who was the dentist? _____

Physician's name _____ **City** _____

Has there been any serious change in health within the last year? _____

If so, what? _____

Are you under care of a physician? _____ If so, why? _____

Are you taking any medication? _____ If so, what? _____

Have you ever had any serious illness or operation? _____

If so, what? _____

Do you now have or have you ever had any of the following? (Circle any that apply)

Abnormal bleeding condition Diabetes Convulsions Fainting spells or seizures

Rheumatic heart disease Infections Anemia

Heart murmur Weight loss AIDS **ALLERGY:**

Rheumatic fever Kidney trouble - to Latex

Congenital heart damage Asthma - to Penicillin

Abnormal heart condition Tuberculosis - to Local anesthetic

Hepatitis, jaundice, or liver disease Painfully swollen joints - to Aspirin, Tylenol, or Codeine

Any additional information not included in the above listed? (Please provide here) _____

Signature _____ **Relationship** _____ **Date** _____