25272 McIntyre St., Suite A - Laguna Hills, CA 92653 - (949) 472-9155

ORTHODONTIC INFORMATION SHEET

PATIENT INFORMATION

Date: ______________________________

Patient's Name ____
Last First Middle

Address: ____
Street City State/Zip

Phone: ____________________ Birthdate: ____________________ SSN: ____________________

If patient is a minor, give parent's or guardian's name: ______________________________

Hobbies: ____

RESPONSIBLE PARTY INFORMATION

Name ____ ____________
Last First Middle Marital Status

Residence: ____
Street City State/Zip

Mailing Address: ____
Street City State/Zip

Home Phone: ____________________ Cell Phone: ____________________

SSN: ______________ Birthdate: ______________ Relationship to Patient: ______________

Employer: ____________________ Occupation: ____________________

Spouse's Name: ____

SSN: ______________ Birthdate: ______________ Relationship to Patient: ______________

Employer: ____________________ Occupation: ____________________

EMERGENCY CONTACT

Name: ______________ Relationship: ______________ Phone#: ______________

Address: ____________________ City: ______________ Zip: ____________

INSURANCE INFORMATION

Insured's Name: ______________________________ Insured DOB: ______________

Dental Insurance Co: ______________________________ Insured SSN: ______________

Insurance Co Phone: ______________ Policy # ______________ Group # ______________

Insurance Co Address: ____________________ City: ______________ Zip: ____________

MEDICAL HISTORY

Condition	YES	NO
Diabetes	☐	☐
Pneumonia	☐	☐
Heart Trouble	☐	☐
Rheumatic Fever	☐	☐
Bone Disorders	☐	☐
Hepatitis	☐	☐
Anemia	☐	☐
Epilepsy	☐	☐
Asthma	☐	☐
History of Joint Replaement	☐	☐

Condition	YES	NO
Kidney Involvement	☐	☐
Tuberculosis	☐	☐
Glaucoma	☐	☐
Prolonged Bleeding	☐	☐
Fainting / Dizziness	☐	☐
Nervous Disorders	☐	☐
Liver Involvement	☐	☐
Endocrine Problems	☐	☐
HIV / AIDS	☐	☐
Current or past Phen fen use	☐	☐
Latex Allergy	☐	☐

Have tonsils and adenoids been removed? YES ☐ NO ☐ At what age? ____________

List any drugs or medications being taken: ____________

List any allergies or drug sensitivities: ____________

DENTAL HISTORY

Question	YES	NO
Have there been any injuries to the face, mouth or teeth?	☐	☐
Has the patient ever sucked a thumb or fingers? Until what age?	☐	☐
Does the patient have any speech problems?	☐	☐
Is the patient a mouth breather?	☐	☐
Have you been informed of any missing or extra permanent teeth?	☐	☐
Has an orthodontist been consulted previously?	☐	☐
Has any member of the family had orthodontic treatment?	☐	☐

Date of last dental examination? ____________

OTHER INFORMATION

Patient's Physician: ____________ Phone# ____________ Last Visit: ____________

Patient's Dentist: ____________ Phone # ____________ Last Visit: ____________

Other Children in Family: Name ____________ Age ______ Name ____________ Age ______

Who may we thank for referring you? ____________

Reason for seeking orthodontic care: ____________

I have read and understand the above questions. I will not hold my orthodontist or any member of his Staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes to my medical or dental status, I will so inform this practice.
Please sign and fax to **949-472-8606**, email to **info@kimfamilyortho.com**, or bring to your next scheduled appoinment.

Patient/Guardian Signature: ____________ Date: ____________

Doctor Signature: ____________ Date: ____________