Welcome to Springfield Orthodontics & Associates!

Please take a few moments to fill out this necessary information that will enable us to better serve you.

PATIENT'S INFORMATION

Name _____Age _____Birth Date _____

What sex were you assigned on your birth certificate ___ M ___ F Preferred pronoun ◯ She ◯ He ◯ They/Them

Address_____City_____ Zip_____

Patient lives with (please circle) Mom/Dad/Guardian Home # _____Cell #_____

Work number if applicable_____ Patient's Preferred Name _____

Name of school attending_____ Grade _____

Interests/Hobbies_____

Are there any emotional/behavioral concerns that may have an impact on our treatment? If yes, please explain:

_____

RESPONSIBLE PARTY INFORMATION

Mother/Guardian Name_____Occupation _____

Address (if different from above) _____

Father/Guardian Name _____ Occupation_____

Address (if different from above) _____

Family E-mail _____ Family members currently being treated _____

Whom can we thank for referring you to our office?_____

DENTAL INSURANCE INFORMATION

Primary Policy Holder's Full Name_____Birthdate_____

Social Security Number _____ Relationship to patient _____

Employer_____

Insurance Company _____Group #_____ID#_____

Secondary Policy Holder's Full Name_____Birthdate_____

Social security Number_____ Relationship to patient_____

Employer_____

Insurance Company _____ Group #_____ID#_____

ORAL HEALTH HISTORY

Dentist _____ Phone _____Last visit_____

Address _____ City _____State _____ Zip_____

MEDICAL HISTORY

Physician name _____Phone _____

Address _____ZIP _____

Are you currently under a physician's care? If yes, please explain_____

Are there any immediate family medical history that could impact our treatment, please explain_____

_____

Are you taking medications? ◯ Yes ◯ No If so, what? _____

Do you have any food or other allergies? ◯Yes ◯No If so, what?_____

IS THERE ANY HISTORY OF: (PLEASE CIRCLE)

Y/N	CLICKING OF JAW (TMJ)	Y/N	SUCK THUMB/FINGERS	Y/N	SPEECH PROBLEM	Y/N	DIFFICULTY CHEWING
Y/N	PAIN IN JOINTS (EARS)	Y/N	TONGUE THRUST HABIT	Y/N	DRY MOUTH	Y/N	EXTRACTION OF TEETH
Y/N	INJURIES TO TEETH	Y/N	MOUTH BREATHING	Y/N	FEVER BLISTERS/ ULCERS	Y/N	MISSING TEETH
Y/N	INJURIES TO FACE	Y/N	PRIOR ORTHODONTICS	Y/N	GRINDING TEETH	Y/N	OTHER

If yes to any of the above, please explain _____

To the best of my knowledge, all the preceding answers are true and correct. I hereby give permission to Dr. Ian Thomas and his Associates and Clinical Team to take necessary x-rays, photos, digital scans or study models to enable complete diagnosis as well as use of these records for educational purposes. I will notify Springfield Orthodontics of any changes in my medical or dental health.

Person Responsible for Account (Printed) _____

Signature of Responsible Party _____Relationship _____Date _____