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 _____ Sex ____M _____F

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

Insurance Subscriber_____Phone_____

Subscriber's Date of Birth_____ Subscriber's Social Security Number_____

Employer_____

Insurance Provider_____ID#_____

2nd Insurance Subscriber_____Phone_____

Subscriber's Date of Birth_____ Subscriber's Social Security Number_____

Employer_____

2nd Insurance Provider_____ID#_____

ORAL HEALTH HISTORY

Dentist_____ Phone_____Last visit_____

Address_____City_____State_____Zip_____

Why are you seeking treatment?_____

MEDICAL HISTORY

Physician name_____Phone_____

Address_____ City_____State_____ZIP_____

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

Date Updated (For office use) _____ _____ _____ _____

Is there any immediate family history of: (please circle)

HEART DISEASE	Y/N	KIDNEY DISEASE	Y/N	NASAL BLOCKAGE	Y/N	EMOTIONALPROBLEMS	Y/N
RHEUMATIC FEVER	Y/N	DIABETES	Y/N	DRUG/ALCOHOL USE	Y/N	PSYCHIATRIC THERAPY	Y/N
HEART MURMUR	Y/N	SEIZURES	Y/N	HEPATITIS/JAUNDICE	Y/N	DIGESTIVE DISORDER	Y/N
HIGH BLOOD PRESSURE	Y/N	ASTHMA	Y/N	TUBERCULOSIS	Y/N	HOSPITALIZATION/ SURGERY	Y/N
AIDS/HIV+	Y/N	ARTHRITIS	Y/N	THYROID DISEASE	Y/N	BLOOD/ DISORDER	Y/N
FREQUENT COLDS	Y/N	BIRTH DEFECT	Y/N	MAJOR ILLNESS	Y/N	OTHER	Y/N

If you answered YES to any of the medical history, please explain_____

_____

Are you taking medications? Y/N If so, what?_____

Do you have any food or other allergies? Y/N 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.

Person Responsible for Account_____

Signature of Responsible Party_____Relationship _____Date _____