Patient History & Information Form

Last Name_____First Name_____Middle Name_____Male/Female_____
Patient/Parent E-mail address_____Family members treated here_____
Nick Name_____Birthdate_____Age_____ S.S.#_____
Home#_____Work_____Cell#_____Pager_____
Address _____City/State/Zip_____
Referred by_____ Dentist_____ Last Visit_____Physician _____

Responsible Party Information

Responsible Party Name_____S.S.#_____
Address_____City/State/Zip_____
Home #_____Work #_____Cell #_____Fax #_____Pager #_____
Birthdate_____Marital Status_____Relationship to Patient_____
Employer_____Occupation_____# Yrs. Emp._____ E-mail address_____
Spouse's Name_____S.S. #_____
Address_____City/State/Zip_____
Home #_____Work #_____Cell #_____Fax #_____Pager #_____
Birthdate_____Marital Status_____Relationship to Patient_____
Employer_____Occupation_____# Yrs. Emp._____ E-mail address_____

Dental Insurance Information

Primary Insured Name_____ Date of Birth_____ SS#_____
Dental Insurance Co._____Phone #_____
Address_____City/State/Zip_____
Secondary Insured Name_____Date of Birth_____ SS#_____
Dental Insurance Co._____Phone #_____
Address_____City/State/Zip_____

Medical and Dental History

Are you under the care of a physician at this time?_____
Is there any medication now being taken?_____If so, please list_____
Are you allergic to any medication?_____List_____
Do you have chronic difficulty breathing through your nose? Y / N Do you or you child snore? Y / N
Have you ever had any baby teeth or permanent teeth removed by your dentist?_____
Any tooth grinding at night?_____
Do you bite your lip, nail or tongue or chew on pencils?_____
Do you suck any fingers, thumb or tongue now?_____
Do you like the way your teeth look?_____
Do you play any musical instrument that touches the lips?_____
Are you sensitive, quiet or outgoing?_____
What is your attitude toward receiving orthodontic treatment?_____
Have you ever seen an orthodontist?_____When?_____
How many times a day do you brush your teeth?_____
Please circle any of the medical conditions that you have had or currently have.

Anemia	Epilepsy	Nervous Disorders	Tuberculosis
Arthritis	Heart Problems	Pneumonia	Tumor or Cancer
Asthma or Hay fever	Hepatitis	Prolonged Bleeding	Other/Explain _____
Bone Disorders	Herpes	Rheumatic Fever	_____
Diabetes	High Blood Pressure	Repeated Headaches	_____
Dizziness	Kidney or Liver Disease	Sexually Transmitted Disease	_____

Are there any medical conditions we have not discussed that you feel we should be aware of? Explain_____

All information is regarded as confidential. By acceptance of Lach Orthodontic Specialists interest free financing programs you agree to credit reporting. By signing this information form allows Lach Orthodontic Specialists to administer treatment. I understand that all conversations may be video and/or audio recorded for quality assurance and training purposes. I hereby give my permission for the use of orthodontic records, including photographs, made in the process of examinations, treatment, and retention for purposes of professional consultations, marketing, research, education, or publication in professional journals as well as send me education information and event updates. Thank you for your cooperation.

Signed_____**Date**_____
Relationship to the patient: _____

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