



**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:** \_\_\_\_\_

