Welcome to our office!

ORTHODONTICS

BRETT E. ECKLEY L. EDWARD ECKLEY

Come smile with us!

PATIENT INFORMATION

Date: _____

Patient's Name: _____ (LAST) _____ (FIRST) _____ (MIDDLE)

Address: _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

Birthdate: _____ / _____ / _____ Social Security Number (SSN): _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email Address: _____

Employer: _____ Occupation: _____ Years Employed: _____

Marital Status (circle one): Single Partnered Divorced Married Separated Widowed

Spouse/Partner Name: _____

Birthdate: _____ / _____ / _____ Social Security Number (SSN): _____

Employer: _____ Occupation: _____ Years Employed: _____ Work Phone: _____

Children:

_____ Birthdate: _____ Age: _____ Male or Female

_____ Birthdate: _____ Age: _____ Male or Female

_____ Birthdate: _____ Age: _____ Male or Female

List any family members who have been or are currently in treatment in our office: _____

_____

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

Hobbies: _____

DENTAL INSURANCE INFORMATION

Insured's Name: _____ (LAST) _____ (FIRST) _____ (MIDDLE) Social Security Number: _____

Relationship to Patient: _____ Birthdate: _____

Insured's Employer: _____ Work Phone: _____

Insurance Company: _____ Group Number: _____

Insurance Phone #: _____

Do you have dual insurance coverage? Yes No If Yes:

Insured's Name: _____ (LAST) _____ (FIRST) _____ (MIDDLE) Social Security Number: _____

Relationship to Patient: _____ Birthdate: _____

Insured's Employer: _____ Work Phone: _____

Insurance Company: _____ Group Number: _____

Insurance Phone #: _____

EMERGENCY INFORMATION

Name of nearest relative not living with you: _____

Relationship to patient: _____ Home Phone: _____ Cell Phone: _____

Address: _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

What main concerns do you want to address with orthodontic treatment? _____

_____

Have you ever been evaluated or had orthodontic treatment before? Yes No

Describe if Yes: _____

_____

Name of patient's general dentist: _____ Date of last visit: _____

Do you require antibiotic premedication before dental procedures? Yes No

Have you ever experienced any of the following?

Y	N	Clenching/Grinding	Y	N	Nail Biting	Y	N	Thumb / Finger Sucking
Y	N	Tongue Thurst	Y	N	Nursing/Bottle Habit			Until what age: _____
Y	N	Lip Sucking / Biting	Y	N	Speech Problems	Y	N	Pacifier Habit
y	N	Mouth Breathing						Until what age: _____

Do you experience frequent headaches? Yes No

Have there been any injuries to the face, mouth, teeth or chin? Yes No

Describe if Yes: _____

Have you been informed of any missing, impacted or extra permanent teeth? Yes No

Describe if Yes: _____

Have you had any pain / tenderness in your joint (TMJ/ MD), ears, temples or cheeks? Yes No

Describe if Yes: _____

Have you ever had any of the following medical problems?

y	N	Adnormal Bleeding	y	N	Cancer/Tumor	y	N	Heart Murmur/Heart Problems	y	N	Mitral Valve Prolapse
y	N	Hemophilia	y	N	Diabetes	y	N	Tuberculosis	y	N	Tonsilities/Adenoiditis
y	N	Anemia	y	N	Epilepsy/Convulsions	y	N	Hepatitis/Jaundice	y	N	Tonsils Removed
y	N	Blood Disease	y	N	Endocrine Problems	y	N	Herpes			Age: _____
y	N	HIV/Aids	y	N	Asthma	y	N	Kidney/Liver Problems	y	N	Adenoids Removed
y	N	Arthritis/Bone Disorder	y	N	Hearing Impairment	y	N	Rheumatic/Scarlet Fever			Age: _____
y	N	Osteoporosis	y	N	Are you or could you be pregnant				y	N	Do you smoke or use Tobacco Products

Physician: _____ Phone: _____ Date of last visit: _____

Are you currently under the care if a physician? Yes No

Describe if yes: _____

_____

Please list all drugs you are allergic or sensitive to: _____

_____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes.

I authorize the dental staff to perform the necessary dental services, including x-rays, I may need.

_____ _____

Signature of Parent of Guardian Date