Patient's Name: ____

Last First Middle Sex

Address: Street City State Zip

Date of Birth: Social Security if over 18: School:

Cell Phone: Home Phone :

Email:

General Dentist: ________________________ Last Visited: ____________________

How did you hear about us? Google / Facebook / Yelp / Instagram / Sports Team / Mailer / Friend / Family / Dentist / Employee ________

If a minor, does patient reside with both parents? ☑ **YES** ☐ **NO** If NO, please explain ________

Primary Responsible Party/Insurance Subscriber Information:

Name:________________________________ Relationship:______________

Address (if different than patient)________________________________

Birthdate: ____________ Email: ________________________ SS# ______________

Insurance Company:______________ ID#______________ EmployerName/Group#______________

Insurance Address:______________________ Insurance Phone#______________________

Secondary Responsible Party/Insurance Subscriber Information:

Name:________________________________ Relationship:______________

Address (if different than patient): ________________________________

Birthdate:____________ Email: ________________________ SSN# ______________

Insurance Company: ______________ Employer Name/Group#______________ ID#______________

Insurance Address:______________________ Insurance Phone#______________________

Emergency Information:

Name of nearest relative not living with you:______________________ Phone #: ______________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPPA)

You may refuse to sign this section

I,________________________, have received a copy of this office's Notice of Privacy Practices.

Name (Please Print)______________________ Signature______________________ Date:____________

FOR PATIENTS OVER THE AGE OF 18

I give consent to the health care professionals at Tru Orthodontics to release my personal records and information to the person/persons listed below…

Name of Person/Persons: Signature of Patient

Medical History	*Patient's Physician* ______		
·	Yes	No	
· Are you in good health?	☐	☐	Explain
· Do you have any history of major illness or hospitalization?	☐	☐	Explain
· Are you currently under the care of a physician?	☐	☐	Explain
· Do you currently take any medications?	☐	☐	List & explain
· Are you allergic to any medications?	☐	☐	List & explain
· Have your tonsils and adenoids been removed?	☐	☐	When?
· Are you pregnant?	☐	☐	
· Have you ever taken bisphosphonates for osteoporosis or other bone disease?	☐	☐	
Is there any other medical conditions we should be aware of?			

Do you currently have or have you ever had any of the conditions listed below? Please check the appropriate response

YES	NO		YES	NO		YES	NO	
☐	☐	Heart Attack	☐	☐	Anemia	☐	☐	Tuberculosis
☐	☐	Heart Murmur	☐	☐	Bleeding Disorders	☐	☐	Asthma
☐	☐	Rheumatic Fever	☐	☐	Hepatitis	☐	☐	Herpes
☐	☐	Rheumatic Heart Disease	☐	☐	HIV/AIDS	☐	☐	Kidney Disorders
☐	☐	Congenital Heart Defect	☐	☐	Diabetes	☐	☐	Epilepsy
☐	☐	Stroke	☐	☐	Leukemia	☐	☐	Fainting/Dizzy Spells
☐	☐	Mononucleosis	☐	☐	Bone Disorders	☐	☐	Endocrine Disorders

Children/Teens Only

- Has either parent had orthodontic treatment? ☐ Yes ☐ No Explain ______
- Has the patient reached puberty? ☐ Yes ☐ No **Boy:** voice changed?☐Yes☐No **Girl**: Started menstruation?☐Yes☐No

Dental History

- When was your last dental exam/cleaning? ______
- Do you have any extra missing, loose, or sensitive? ☐ Yes ☐No Explain______
- Any injuries to your face, mouth, or teeth? ☐ Yes ☐ No Explain______
- Do you currently suck your thumbs or fingers? ☐ Yes ☐ No Explain______
- Do you have any speech problems? ☐ Yes ☐ No Explain______
- Are you a mouth-breather? ☐ Yes ☐ No
- Any clicking, popping, or pain in your jaw joint (TMJ)? ☐ Yes ☐No Explain______
- Do you clench or grind your teeth? ☐ Yes ☐No
- Do you suffer frequent headaches? ☐ Yes ☐No Explain______
- Does your jaw ever hurt? ☐ Yes ☐ No When?______
- Have you ever had an orthodontic evaluation before? ☐ Yes ☐No May we ask, who did you see?______
- ***Please tell why you are interested in orthodontia?*** ______

The information given about my health history in this form is accurate and complete to the best of my knowledge. I hereby give my consent to perform necessary diagnostic tests, including x-rays to evaluate my dental health. I agree that all of the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidences and it is my responsibility to inform this office of any changes in my medical status. I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office.

Signature of patient ***Signature of parent*** ***Signature of guardian*** ***Date***