

Orthodontic Patient Information Sheet

Patient Information

Patient Full Name: _____

Nickname: _____

Telephone: _____

Patients Address: _____

Cellphone: _____

Birthdate _____

Age: _____

Sex: _____

Email address: _____

School/Employer: _____

Grade/Position _____

Interest/Sports _____

Responsible Party Information

Primary Mother Father Step Parent Self Other (specify) _____

Responsible Party: _____

Telephone: _____

Address: _____

Cellphone: _____

Employer: _____

Email address: _____

Social Security Number: _____

Secondary Mother Father Step Parent Self Other (specify) _____

Responsible Party: _____

Telephone: _____

Address: _____

Cellphone: _____

Employer: _____

Email address: _____

Social Security Number: _____

Referral Information

How Did You Hear About Us? Dentist Patient Yellow Pages Internet Other _____

Whom May We Thank For Referring You To Us? _____

Present Dentist: _____

Reason For Consultation: _____

Medical History (Circle Yes or No for which the patient has a history)

Aids	Y N	Cerebral palsy	Y N	Emotional disorders	Y N	Organ transplant	Y N
Allergies	Y N	Chronic neck pain	Y N	Epilepsy	Y N	Painful chewing	Y N
Anemia	Y N	Clicking of jaw	Y N	Fainting, Dizziness	Y N	Periodontal problems	Y N
Arthritis	Y N	Jaw pain	Y N	Headaches	Y N	Pregnant	Y N
Aspirin	Y N	Cold Sores/Herpes	Y N	Heart condition	Y N	Rheumatic Fever	Y N
Asthma	Y N	Diabetes	Y N	Hepatitis A, B or C	Y N	TMJ problems	Y N
Autoimmune	Y N	Downs Syndrome	Y N	High Blood Pressure	Y N	Tobacco use	Y N
Bone disorders	Y N	Drug allergies	Y N	Joint Replacement	Y N	Tooth Grinding	Y N
Bulimia	Y N	Drug/Alcohol Abuse	Y N	Muscular disorders	Y N	Tuberculosis	Y N
Cancer	Y N	Endocrine problems	Y N	Neurological disorders	Y N	Venereal Disease	Y N

Any disease, problems, or allergies not mentioned above? _____

Current Medications? _____

Any face, mouth or teeth injuries? _____

Are there any missing or extra teeth? _____

Have you or any family member been to our office previously? Yes/No If Yes, whom? _____

Insurance Information (Please fill out completely so we may properly file your insurance)

Name of Primary Orthodontic Insurance: _____ Telephone: _____

Name of Policy Holder: _____ Mother Father Step Parent Self Other (specify) _____

Policy Holders Birthdate: _____

Signature: _____ Relationship To Patient: _____ Date: _____

I hereby authorize OrthoBanc, LLC, on behalf of Dr Robert Colter LLC, to obtain a copy of my credit report from a credit reporting agency for the purpose of considering payment options.