WELCOME
To Dr. Taylor Orthodontics

PATIENT INFORMATION

Today's Date _____

Name _____ Birthdate _____ Age _____
First Last

Address _____ Phone _____
Street City Zip

Email _____ Male ☐ Female ☐

Hobbies _____ Referred by _____

Occupation _____ Employer _____

Work # _____

SPOUSE INFORMATION (If Applicable)

Spouse's Name _____

Phone _____

DENTAL INSURANCE INFORMATION

Name of Insured (Who has the insurance?)_____

Birth date_____ Social Security Number_____

Insurance Company Name _____

Insurance Company Phone _____ ID Number _____

Please provide us with a copy of your dental insurance card. If you have coverage with more than one insurance company, please copy both insurance cards. Thank you!

MEDICAL AND DENTAL HISTORY

Dentist _____ City _____ Phone _____
Physician _____ City _____ Phone _____

Have you had any major illness, surgery, medical problems? ☐ Yes ☐ No
List (if applicable) _____

List any medications you are currently taking_____

Are you taking Bisphosphonates? ☐ Yes ☐ No

For Women: Are you taking birth control pills? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No

List any medications you are allergic to _____

List any other allergies (latex gloves, metals, etc.)_____

Are you currently in good health? ☐ Yes ☐ No

Do you require antibiotics prior to having routine dental treatment? ☐ Yes ☐ No

Have you ever had any of the following medical problems?

☐ Y	☐ N	Abnormal Bleeding	☐ Y	☐ N	HIV+/AIDS
☐ Y	☐ N	Diabetes	☐ Y	☐ N	Kidney / Liver Problems
☐ Y	☐ N	Blood Transfusion	☐ Y	☐ N	Tuberculosis (TB)
☐ Y	☐ N	Hepatitis	☐ Y	☐ N	Asthma
☐ Y	☐ N	Rheumatic / Scarlet Fever	☐ Y	☐ N	Bone Disorders
☐ Y	☐ N	Heart Defect / Murmur	☐ Y	☐ N	Nervous Disorders
☐ Y	☐ N	Cancer	☐ Y	☐ N	Epilepsy / Convulsions

Have there been any injuries to your face, mouth, teeth, or chin? ☐ Yes ☐ No
Are you aware of any missing or extra permanent teeth? ☐ Yes ☐ No
Have you had any jaw joint (TMJ) symptoms or problems? ☐ Yes ☐ No
Have you had any previous orthodontic treatment? ☐ Yes ☐ No

Are you aware of any of the following conditions?

☐ Y	☐ N	Grinding / Clenching Teeth	☐ Y	☐ N	Bleeding Gums
☐ Y	☐ N	Abnormal Wear of Teeth	☐ Y	☐ N	Unusual (excess) Tarter Buildup
☐ Y	☐ N	Speech Problems	☐ Y	☐ N	Lip Sucking / Biting

Reason for your visit_____

_____
Patient's Signature