

## WELCOME TO OUR OFFICE

### Patient Information Form

Please assist us by completing the following questions: Date \_\_\_\_\_

Name \_\_\_\_\_

Last First Middle Nickname

Address \_\_\_\_\_

Street City State Zip

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ City \_\_\_\_\_

Physician \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Please list favorite hobbies or sports \_\_\_\_\_

List family members we have seen \_\_\_\_\_

### PERSON RESPONSIBLE FOR ACCOUNT

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Email Address for Appointment Reminders \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Employer \_\_\_\_\_ SS# \_\_\_\_\_

Name of Dental Insurance Co. \_\_\_\_\_ Group ID# \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

### CHILD PATIENT

School \_\_\_\_\_ Grade \_\_\_\_\_

Father's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Employed by \_\_\_\_\_ Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Employed by \_\_\_\_\_ Phone \_\_\_\_\_

Patient lives with: both parents  mother  father

Number of brothers \_\_\_ age ( ) ( ) ( ) ( ) Number of sisters \_\_\_ ages ( ) ( ) ( ) ( )

### ADULT PATIENT

Occupation \_\_\_\_\_ Employed by \_\_\_\_\_ Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Occupation \_\_\_\_\_ Employed by \_\_\_\_\_

– Please continue on reverse side –

# HEALTH HISTORY

**DO YOU HAVE OR HAVE YOU HAD THE FOLLOWING:**

**YES NO**

Heart Disease

Heart Murmur

If yes, is premedication indicated? \_\_\_\_\_

Cancer

Ulcer

Diabetes

Epilepsy

Rheumatic Fever

Sinus Trouble

Arthritis

Stroke

Frequent Cough

Prolonged Bleeding

**YES NO**

Congenital Heart Lesions

Abnormal Blood Pressure

Tuberculosis or Lung Disease

Radiation or X-ray Therapy

AIDS or Immune Suppressive Disorders

Hepatitis, Jaundice, or Liver Disease

Recent Weight Gain or Loss

Artificial Heart Valves or Joints

Fainting or Dizzy Spells

Asthma or Hay Fever

Venereal Disease or Syphilis

Chemical or Alcohol Dependency

Latex Allergy

Pregnancy

Does the patient have any allergies i.e. medications etc.? \_\_\_\_\_

Does the patient have any special problems that have not been mentioned above? \_\_\_\_\_

What is the patient or parents' orthodontic concern? \_\_\_\_\_

Does the patient have any clicking or pain in the jaw joints?  Yes  No \_\_\_\_\_

Does the patient clench or grind his/her teeth?  Yes  No \_\_\_\_\_

Has the patient ever had periodontal disease? \_\_\_\_\_

Did the patient ever suck his/her thumb or fingers?  Yes  No If yes, to what age? \_\_\_\_\_

Has the patient ever worn an orthodontic appliance? \_\_\_\_\_

If yes, what type and when: \_\_\_\_\_

The information of this form is true and complete to the best of my knowledge.

I hereby authorize Dr. Montgomery's office to inquire as necessary into my credit history and standing.

Signature \_\_\_\_\_ Date \_\_\_\_\_

I have reviewed this office's Notice of Privacy Practices.

Patient Name \_\_\_\_\_

Patient (or Parent) Signature \_\_\_\_\_ Date \_\_\_\_\_

I authorize Alan B. Montgomery, D.D.S., M.S. to release information that may be necessary to request claim reimbursement from insurance companies I may designate. I also assign claim payments to be payable to Alan B. Montgomery, D.D.S., M.S.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_