I SONG ORTHODONTICS

New Patient Information

Patient Information

Date _____

Patient's Legal Name _____ Nickname _____

Address _____

Birth Date _____/_____/_____ Age _____ Sex _____

Cell Phone _____ Ok to text ___ Home Phone _____ Email _____

School _____ Grade _____

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

General Dentist _____ City _____

Relatives in treatment at our office: Name _____ Name _____

Chief Concern: _____

Responsible Party Information

Guardian #1 Name (or Self) _____

Address _____

Address (if less than 3 yrs) _____

Cell Phone _____ Ok to text ____ Home Phone _____Work Phone _____

Address _____

Employer _____ Occupation _____

Guardian #2 Name (or Spouse) _____

Address _____

Address (if less than 3 yrs) _____

Address _____

Employer _____Occupation _____

Person financially responsible for this account:

_____ Phone # _____

Orthodontic Insurance Information

Primary Insurance

Insured's Name _____ Birth Date _____/_____/_____ SSN _____ - _____ - _____

Insurance Company _____ Group No. _____ Employer_____

Insurance Co Address _____ _____ Phone _____

Do you have dual coverage? ❑ Yes ❑ No

Secondary Insurance

Insured's Name _____ Birth Date _____/_____/_____ SSN _____ - _____ - _____

Insurance Company _____ Group No. _____ Employer _____

Insurance Co Address _____ Phone _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

TURN OVER ⇨

Medical History

Is patient in Good health? _____ ❑ Yes ❑ No
Name and address of Physician:

_____

Have you had any serious illness or operation? ❑ Yes ❑ No
If yes, please explain:

_____

Have you been hospitalized or had serious illness within the past five years? ❑ Yes ❑ No

If yes, please explain:

ASTHMA	❑ Yes ❑ No	CANCER	❑ Yes ❑ No	HIGH BLOOD PRESSURE	❑ Yes ❑ No
DIABETES	❑ Yes ❑ No	ANEMIA	❑ Yes ❑ No	PROLONGED BLEEDING	❑ Yes ❑ No
PNEUMONIA	❑ Yes ❑ No	EPILEPSY	❑ Yes ❑ No	FAINTING OR DIZZINESS	❑ Yes ❑ No
HEART TROUBLE	❑ Yes ❑ No	NERVOUS DISORDER	❑ Yes ❑ No	LIVER INVOLVEMENT	❑ Yes ❑ No
RHEUMATIC FEVER	❑ Yes ❑ No	TUBERCULOSIS	❑ Yes ❑ No	KIDNEY INVOLVEMENT	❑ Yes ❑ No
BONE DISORDERS	❑ Yes ❑ No	TMJ/TMD SYMPTOMS	❑ Yes ❑ No	ENDOCRINE PROBLEMS	❑ Yes ❑ No
HEPATITIS	❑ Yes ❑ No	AIDS/HIV	❑ Yes ❑ No	VENEREAL DISEASE	❑ Yes ❑ No

Have tonsils and adenoids been removed? What age? _____ ❑ Yes ❑ No
Are you allergic to any of the following?

❑ Yes ❑ No	Aspirin / Ibuprofen	❑ Yes ❑ No	Penicillin	❑ Yes ❑ No	Latex, Metal, Plastic
❑ Yes ❑ No	Sulfa Drugs / Sulfities / Sulfides	❑ Yes ❑ No	Codeine	❑ Yes ❑ No	Local Anesthetics

Other _____
_____

Please list all medications you are currently taking?

_____
_____
_____

Dental History

Have there been injuries to the face, mouth, or teeth? _____ ❑ Yes ❑ No
Has the patient ever sucked a thumb or finger? Until what age? _____ ❑ Yes ❑ No
Does the patient have any speech problems? _____ ❑ Yes ❑ No
Have you been informed of any missing or extra permanent teeth? _____ ❑ Yes ❑ No
Has an orthodontist been consulted previously? _____ ❑ Yes ❑ No
Has either parent or patient had orthodontic treatment? _____ ❑ Yes ❑ No

Signature _____ **Date** _____

Doctor's Signature _____ **Date** _____

Update to Medical History

Date	Comments	Dr Signature	Patient/Guardian Signature