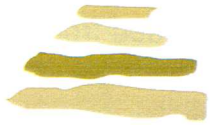

PINE TOP
ORTHODONTICS
russell h. ford, dmd, ms
ryan d. frost, dds, mha

Date: _____

PATIENT INFORMATION

Patient's Name: _____
Last First Middle

Address: _____
Street City State Zip Code

Home Phone: _____ Birthdate: _____ Age: _____

Who is your General Dentist?: _____

How did you hear about our office? _____

LEGAL GUARDIAN INFORMATION

Name: _____
Last First Middle Marital Status

Relationship to Patient: _____

Address (if different from above):

_____
Street City State Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address (*for confirmation of appts ONLY*): _____

Spouse: _____
Last First Middle

Relationship to Patient: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address (*for confirmation of appts ONLY*): _____

How would you prefer to be contacted for appointment reminders (i.e., phone, text, e-mail)? _____

DENTAL INSURANCE INFORMATION

Insured's Legal Name: _____ SS or ID #: _____ Birthdate: _____

Insured's Address (if different from above):

_____
Street City State Zip Code

Insurance Co.: _____ Group #: _____ Telephone #: _____

Insurance Co. Address: _____
Street City State Zip Code

Insured's Employer: _____

Do you have secondary insurance? If yes please complete the section below:

Insured's Legal Name: _____ SS or ID #: _____ Birthdate: _____

Insured's Address (if different from above):

_____
Street City State Zip Code

Insurance Co.: _____ Group #: _____ Telephone #: _____

Insurance Co. Address: _____
Street City State Zip Code

Insured's Employer: _____

(Continued on back)

(Continued from front)

DENTAL HISTORY

What would you like to change about your smile?

Have you been evaluated or had orthodontic treatment? Y N

Do you feel there is too much or too little gum tissue showing when you smile? Y N

Have your adenoids or tonsils been removed? Y N

Have you ever had any pain or tenderness in your jaw joint (TMJ/TMD)? Y N

HABITS

Did you or do you have any of the following habits?:

Clenching/Grinding teeth	Y	N	Thumb/Finger sucking	Y	N
Lip sucking/biting	Y	N	Tongue thrust	Y	N
Mouth breather	Y	N			

MEDICAL HISTORY

Your current physical health is: Good Fair Poor

Have you ever had any of the following medical problems?

Arthritis	Y	N	Handicaps/Disabilities	Y	N
Asthma	Y	N	Hearing impairment	Y	N
Bleeding disorder	Y	N	Heart problems	Y	N
Blood pressure problem:	Y	N	Hepatitis	Y	N
Chemo/Radiation	Y	N	Kidney/Liver defects	Y	N
Convulsions/Epilepsy	Y	N	Mitral valve prolapse	Y	N
Diabetes	Y	N	Sinus problems	Y	N

Are you taking any medications? Y N

If yes, please list each one:

Have you ever taken bisphosphonate drugs (Fosamax, Boniva) used to treat osteoporosis or multiple myeloma)? Y N

For Women: Are you pregnant? Y N

If yes, Week #:

Are you allergic to any of the following?:

Any metals	Y	N	Latex	Y	N
Dental Anesthetics	Y	N	Penicillin	Y	N

Other:

Please elaborate on any other dental or medical concerns:

Signature (Parent/Legal Guardian if minor): Date:

Reviewed by Dr. Ford/Dr. Frost: Date: