

Please **COMPLETE ALL** information. Thank you.

PATIENT INFORMATION

WELCOME TO OUR OFFICE!

A B C

Patient # _____ Patient Age _____
Patient's Name _____
Last First Middle
Address _____
Street City State Zip
Home Phone _____ Birth Date _____ Social Security # _____
If patient is a minor, give parent or guardian's name _____
Office location preference (**circle one**) Crown Point Merrillville Schererville Valparaiso
Responsible party e-mail address _____

How did you hear about our office?

RESPONSIBLE PARTY INFORMATION

Name _____
Last First Middle Marital Status
Residence _____
Street City State Zip
Mailing Address _____
Street City State Zip
How long at this address _____ Own or Rent
Previous address (if less than 3 years) _____
Street City State Zip
Home Phone _____ Work Phone _____ Cell Phone _____
Social Security # _____ Birth Date _____ Relationship to Patient _____
Employer _____ Occupation _____ # years employed _____
Spouse's Name _____
Last First Middle Relationship to Patient
Marital Status _____ Spouse's Social Security # _____
Spouse's Mailing Address _____
Street City State Zip
Spouse's Employer _____ Occupation _____ # years employed _____
Spouse's Birth Date _____ Spouse's Work Phone _____
Spouse's Cell Phone _____

EMERGENCY INFORMATION

Name of Nearest Relative not living with you _____
Complete Address _____
Phone _____ Relationship to Patient _____

I understand that I will be responsible for all lab fees incurred in the fabrication of a splint or orthodontic appliance in the event that I choose not to continue treatment. I understand that it is policy of Puntillo & Crane Orthodontics that the parent who requests treatment for a minor child shall be responsible for all services rendered.

INITIAL _____

To enable us to better set the terms of credit for you or your child's care, today we will obtain the appropriate credit bureau reports.

Signature _____

Date _____

INSURANCE INFORMATION

Insured's Name _____ DOB _____ Insured's ID# _____
Insured's Address _____ Ins Co. Phone _____
Insurance Company _____ Group # _____
Insured's Employer _____
Do you have dual coverage? Yes () No () If yes, please continue: _____
Insured's Name _____ DOB _____ Insured's ID# _____
Insurance Company _____ Group # _____
Insured's Address _____ Phone _____
Insured's Employer _____

****Your answers are for office records only and are kept confidential. A thorough medical history is essential to a complete orthodontic evaluation.****

Medical History

Have you ever had any of the following? Please circle YES or NO.

- | | |
|--|--|
| Yes or No - Birth defects or hereditary problems | Yes or No - Bone fractures or major injuries |
| Yes or No - Any injury to the head, neck, or face | Yes or No - Arthritis or joint problems |
| Yes or No - Endocrine or thyroid problems | Yes or No - Diabetes or low blood sugar |
| Yes or No - Kidney problems | Yes or No - Cancer, tumor |
| Yes or No - Radiation or chemotherapy | Yes or No - Stomach ulcer or acid reflux |
| Yes or No - Immune system problems | Yes or No - Osteoporosis |
| Yes or No - Sexually transmitted disease | Yes or No - AIDS or HIV positive |
| Yes or No - Hepatitis, jaundice, other liver problems | Yes or No - Polio, Mono, TB, or Pneumonia |
| Yes or No - Seizures, fainting spells | Yes or No - Depression |
| Yes or No - Vision or hearing problems | Yes or No - History of Anorexia or Bulimia |
| Yes or No - High or low blood pressure | Yes or No - Bruise easily, Anemia |
| Yes or No - Chest pain, shortness of breath, tire easily | Yes or No - Swollen ankles |
| Yes or No - Heart defect, murmur, heart attack | Yes or No - Sickle Cell Disease |
| Yes or No - Mitral Valve Prolapse, heart disease | Yes or No - Stroke |

Yes or No - Skin disorder (other than acne)

Yes or No - Frequent headaches or migraines

Yes or No - Asthma, sinus problems, hay fever

Yes or No - Speech problem and/or therapy

Yes or No - Tonsil or adenoid condition

Yes or No - Latex or Nickel sensitivity

Yes or No - Cold sores/fever blisters

Yes or No - Nervous/Anxious

Yes or No - Rheumatic Fever

Yes or No - Hemophilia, Excessive bleeding

YES

NO

Are you currently undergoing any medical treatment?

()

()

If YES, for what? _____

Who is your physician? _____

Are you currently taking any medications?

()

()

If YES, please list all medications. _____

Are you allergic to any medications?

()

()

If YES, please list. _____

Do you have any allergies (for example: cats, milk, seasonal)?

()

()

If YES, please list. _____

Are you pre-medicated for major dental work and cleanings?

()

()

Do you chew or smoke tobacco?

()

()

If you are a woman, are you pregnant?

()

()

Are there any other health problems not listed?

()

()

If YES, please describe. _____

Dental History

	YES	NO
Any dental pain or problems needing attention? If YES , please describe. _____	()	()
Have you every bumped, chipped, or fractured any teeth?	()	()
Do you snore?	()	()
Is it difficult to breathe through your nose?	()	()
Do you breathe with your mouth constantly open?	()	()
Do you have any of the following habits? Please circle. Thumb, finger, lip, or pacifier sucking, finger nail biting, biting other objects Other _____		

TMJ (Jaw Joint) History

	YES	NO
Do you or have you ever had a TMJ problem?	()	()
If YES , have you ever been treated?	()	()
By whom? _____		
When? _____		
Please describe your problem and/or concern: _____ _____		

I represent that all the statements and answers contained herein, are to the best of my knowledge and belief, complete, true and correctly recorded and it is agreed that **Puntillo and Crane Orthodontics P.C.**, and staff shall not be presumed to have knowledge of any information not so recorded.

Patient's
Signature: _____ Date: _____
(Parent if patient is a minor)