Patient Information			
Patient Age:			
Patient First Name:	Middle Initial:	Patient Last Name:	
Address:	City:	State:	Zip:
Home Phone:	Birth Date:	Social Security #:	
If patient is a minor, give parent or guardian's name:			
Office location preference (Crown Point, Merrillville, Schererville, Valparaiso):			
How did you hear about our office?			

Responsible Party Information			
Last Name:	First Name:	Middle Initial:	Marital Status:
Address:	City:	State:	Zip:
Mailing Address:	City:	State:	Zip:
How long at this address?	Own or Rent?		
Previous address (if less than 3 years):			
Home Phone:	Work Phone:	Cell Phone:	
Social Security #:	Birth Date:	Relationship to Patient:	
Employer:	Occupation:	# of Years Employed:	
Spouse's Last Name:	Spouse's First Name:	Spouse's Middle Name:	Relationship to Patient:
Marital Status:	Spouse's Social Security #:		
Spouse's Mailing Address:			
Spouse's Employer:	Occupation:	# of Years Employed:	
Spouse's Birth Date:	Spouse's Work Phone:	Spouse's Cell Phone:	
Spouse's e-mail address:			

Emergency Information	
Name of Nearest Relative not living with you:	
Completed Address:	
Phone:	Relationship to Patient:

Insurance Information		
Insured's Name:	DOB:	Insured's ID#:
Insured's Address:	Insurance Company Phone:	
Insurance Company:	Group #:	
Insured's Employer:		
Do you have dual coverage? If so, please continue		
Insured's Name:	DOB:	Insured's ID#:
Insured's Address:	Insurance Company Phone:	
Insurance Company:	Group #:	
Insured's Employer:		

Medical History	
****Your answers are for office records only and are kept confidential. A thorough medical history is essential to a complete orthodontic evaluation.****	
Have you ever had any of the following?	
Birth defects or hereditary problems	Bone fracture or major injuries
Any injury to the head, neck, or face	Arthritis or joint problems
Endocrine or thyroid problems	Diabetes or low blood sugar
Kidney problems	Cancer, tumor
Radiation or chemotherapy	Stomach ulcer or acid reflux
Immune system problems	Osteoporosis
Sexually transmitted disease	AIDS or HIV positive
Hepatitis, jaundice, other liver problems	Polio, Mono, TB, or Pneumonia
Seizures, fainting spells	Depression

Vision or hearing problems	History of Anorexia or Bulimia
High or low blood pressure	Bruise easily, Anemia
Chest pain, shortness of breath, tire easily	Swollen ankles
Heart defect, murmur, heart attack	Sickle Cell Disease
Mitral Valve Prolapse, heart disease	Stroke
Skin disorder (other than acne)	Frequent headaches or migraines
Asthma, sinus problems, hay fever	Speech problem and/or therapy
Tonsils or adenoid condition	Latex or Nickel sensitivity
Cold sores/fever blisters	Nervous/Anxious
Rheumatic Fever	Hemophilia, Excessive bleeding
Are you currently undergoing any medical treatment?	Take Bisphosphonates?
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?	
If YES, please list the medication.	
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	
Dentist Name:	Dentist Location:
Any dental pains or problems needing attention?	
If YES, please describe.	
Have you ever bumped, chipped, or fractured any teeth?	
Do you snore?	
Is it difficult to breathe through your nose?	
Do you have any of the following habits?	

Thumb, finger, lip or pacifier sucking	Finger or nail biting
Biting other objects	Other (explain)

TMJ (Jaw Joint) History
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 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.

Please 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:

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 (Parent if patient is a minor):	Date: