YOUNG orthodontics

YOUNG SMILES. TIMELESS BEAUTY.
1055 W Queen Creek Rd, Suite 5, Chandler, AZ 85248

NEW PATIENT INFORMATION

Today's Date _____

Patient Name _____ Nickname _____

Address _____ ZIP _____

Email (For appointment reminders) _____

Birth Date ____/____/____ Age ____ Sex ____ Cell Phone _____ Home Phone _____

School (If applicable) _____

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

General Dentist _____ City _____

Siblings/Children: Name _____ Age ____ Name _____ Age ____

RESPONSIBLE PARTY INFORMATION

Primary Parent/Spouse _____

Address _____

Cell Phone _____ Home Phone _____ Work Phone _____

Social Security Number ___ - ___ - _____ Birth Date ____/____/____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Secondary Parent _____

Address _____

Cell Phone _____ Home Phone _____ Work Phone _____

Social Security Number ___ - ___ - _____ Birth Date ____/____/____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Person financially responsible for this account: ☐ Self ☐ Father ☐ Mother ☐ Other _____

Marital status: ○ Single ○ Married ○ Divorced ○ Widowed

ORTHODONTIC INSURANCE INFORMATION

Insured's Name _____ Birth Date ____/____/____ Social Security Number ___ - ___ - _____

Employer _____ Insurance Company _____

Member ID _____ Group No. _____

Insurance Co Address _____ Phone _____

Do you have dual coverage? ○ Yes ○ No

2nd Insured's Name _____ Birth Date ____/____/____ Social Security Number ___ - ___ - _____

Employer _____ Insurance Company _____

Member ID _____ Group No. _____

Insurance Co Address _____ Phone _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____ Phone _____

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MEDICAL HISTORY

Patient's Height _____ Patient's Weight _____

Is patient in good health? . . . . . O Yes O No
Does patient have a history of major illness? . . . . . O Yes O No
Do you have a family history of headaches? . . . . . O Yes O No
Has patient been under the care of a physician for a major illness? . . . . . O Yes O No
Have tonsils and adenoids been removed? . . . . . O Yes O No What age? _____

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

List any drugs or medications now being taken and give reason: _____

_____

_____

List any drug allergies or drug sensitivities: _____

_____

Please acknowledge this information is correct by initialing here _____

DENTAL HISTORY

Have there been injuries to the face, mouth, or teeth? . . . . . O Yes O No
Does the patient have any speech problems? . . . . . O Yes O No
Have you been informed of any missing or extra permanent teeth? . . . . . O Yes O No
Has an orthodontist been consulted previously? . . . . . O Yes O No
Has either parent or patient had orthodontic treatment? . . . . . O Yes O No
Has the patient ever sucked a thumb or finger? . . . . . O Yes O No Until what age? _____
Chief concern for visit? _____
Please explain any additional information you would like to address today: _____

_____

_____

_____

_____

_____ _____

Doctor Signature Date