lake jackson
orthodontics

Today's Date:_____
Patient's Full Name:_____ Preferred Name:_____
☐Male ☐Female Age:_____ Date of Birth:_____ Preferred Phone:_____
Preferred Email Address: _____
Patient's Dentist:_____ Patient's Physician:_____
Person Responsible for Account:_____ Social Security #:_____
Account Holders Address:_____ Phone:_____
Insurance Company:_____ Insurance Phone #:_____
Policy Holder's Name:_____ Date of Birth:_____ Social Security #:_____
Employer :_____
Relatives Treated at Our Office:_____
How did you hear about our office?_____

Child/Minor

School:_____ Grade:_____
Father's Name:_____ Father's Address:_____
Father's Employer:_____ Bus. Address:_____ Phone #:_____
Mother's Name:_____Mother's Address:_____
Mother's Employer:_____ Bus. Address:_____ Phone # :_____

Adult

Home Address: _____
Employed by:_____ Bus. Address:_____ Phone #:_____
Spouse's Full Name:_____ Spouse's Employer:_____ Phone #:_____

Medical History Please check any of the following for which you have been treated:

☐Diabetes	☐Anemia	☐Epilepsy	☐Fainting or Dizziness
☐Pneumonia	☐Asthma	☐Nervous Disorder	☐Hepatitis or Jaundice
☐Heart Trouble	☐Rheumatic Fever	☐Kidney Trouble	☐HIV
☐Bone Disorder	☐Tuberculosis	☐Endocrine Problem	☐Prolonged Bleeding

List any medications currently being taken:_____
List any allergies or drug sensitivity: _____
Have your tonsils or adenoids been removed? (At what age?___)..... ☐ Yes ☐ No
Have you ever sucked your thumb or finger? (Until what age?___)..... ☐ Yes ☐ No
Do you have any speech problems?..... ☐ Yes ☐ No
Are you a mouth breather?..... ☐ Yes ☐ No
Do you play a musical wind instrument?..... ☐ Yes ☐ No
Are you pregnant?..... ☐ Yes ☐ No

How did you hear about our office?_____
Signature of Patient, Parent, or Guardian:_____ Date:_____

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