BILLY POWELL ORTHODONTICS

Patient Information

Today's Date _____

Patient's Full Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____
Date of Birth _____ Age _____
Sex: Male Female
School Attending _____
Whom may we thank for referring you to our office? _____

Dentist _____ Dental Group _____
Address _____
Phone # _____

Responsible Party Information

Name or guardian's name child lives with _____
Relationship to patient _____
Responsible party full name _____
Resident Address _____
City _____ State _____ Zip _____
Mailing Address (if different) _____
_____
Home Phone _____
Cell Phone Mom _____ Dad _____

Father's Name _____
Social Security # _____
Date of Birth _____
Employer _____ Work # _____
Email Address _____

Mother's Name _____
Social Security # _____
Date of Birth _____
Employer _____ Work # _____
Email Address _____

Please Turn Over For More Information

Insurance Information

Primary

Dental Insurance Name _____
Insured Person _____
Social Security # _____ DOB _____
Employer _____
Insurance Address _____
City _____ State _____ Zip _____
Insurance Phone # _____ Group # _____

Secondary

Dental Insurance Name _____
Insured Person _____
Social Security # _____ DOB _____
Employer _____
Insurance Address _____
City _____ State _____ Zip _____
Insurance Phone # _____ Group # _____

Health Questionnaire

Name of Physician _____
Date of last exam _____

Do you have or use any of the following (indicate with an "x"):

___Teeth sensitive to cold, heat, sweets, or pressure
___Food Impaction
___Burning of Tongue
___Frequent blisters on lips or mouth
___Unusual sounds in ear while eating
___Unpleasant taste
___Complications from extractions
___Orthodontic treatment
___Oral habits (fingernail biting, cheek biting)
___Frequency of brushing _____x a day
___Water jet device
___Bleeding Gums
___Clenching or grinding teeth
___Swelling or lumps in mouth
___Pain around ear
___Bad Breath
___Unfavorable dental experience
___Periodontal treatment
___Mouth breathing
___Cigarettes, pipe or cigar smoking
___Dental Floss
___Fluoride supplements

Medical History

___Allergies to drugs
___Any heart ailments
___Excessive bleeding
___Asthma
___Kidney problems
___Psychiatric/emotional care
___Stroke
___Eye Disorders
___Tuberculosis
___Venereal disease
___Allergies to anesthetics
___Neurological disorders
___Anemia/blood problems
___Hay fever/allergies
___Liver problems/hepatitis
___Rheumatic fever
___Thyroid disorders
___Tonsillitis
___Ulcer or colitis
___Injuries to the mouth/jaw
___High Blood Pressure
___Radiation treatments
___Arthritis
___Diabetes
___Malignancies
___Sinus problems
___Immune System Disorders (HIV, AIDS)
___Tuberculosis
___Pregnancy, if so, what month _____
___Recurrent headaches, if so, location
___Front ___Back of head ___Side

Describe any current medical treatment including drugs taking, including those not listed above:

_____
_____

Signature of responsible party _____ Date _____