



PATIENT INFORMATION

DATE _____

Last Name	First Name	Nickname	S.S. Number	Sex	Date of Birth	Age
Address		City	State	Zip	Phone	
School (If a Student)	Grade	single <input type="checkbox"/> married <input type="checkbox"/> sep <input type="checkbox"/> divorced <input type="checkbox"/> widow(er) <input type="checkbox"/>	Employed By/Occupation		Business Phone	
Referred By	Name of General Dentist				Date of Last Visit	

PARENT INFORMATION (please complete if patient is a minor)

Father's Name	single <input type="checkbox"/> married <input type="checkbox"/> separated <input type="checkbox"/> divorced <input type="checkbox"/> widower <input type="checkbox"/>	Mailing Address	City	State	Zip	Home Phone
Social Security No.		Birthdate	Employed By/Occupation		Business Phone	
Mother's Name	single <input type="checkbox"/> married <input type="checkbox"/> separated <input type="checkbox"/> divorced <input type="checkbox"/> widower <input type="checkbox"/>	Mailing Address	City	State	Zip	Home Phone
Social Security No.		Birthdate	Employed By/Occupation			
E-Mail Address: _____						

INFORMATION ABOUT PERSON RESPONSIBLE FOR THIS ACCOUNT

Name	Relationship to Patient	Employed By/Occupation		Phone
Mailing Address		City	State	Zip
				Business Phone
Spouse's Name	Employed By/Occupation		Work Phone	

MEDICAL/DENTAL HISTORY

Is the patient in good health? _____	Yes <input type="checkbox"/> No <input type="checkbox"/>	<p><i>Please check any of the following conditions or problems</i></p> <table border="0"> <tr> <td>Asthma <input type="checkbox"/></td> <td>Fainting/dizziness <input type="checkbox"/></td> </tr> <tr> <td>Bone (fracture) <input type="checkbox"/></td> <td>Hearing <input type="checkbox"/></td> </tr> <tr> <td>Seizures <input type="checkbox"/></td> <td>Heart Trouble <input type="checkbox"/></td> </tr> <tr> <td>Diabetes <input type="checkbox"/></td> <td>Kidney Trouble <input type="checkbox"/></td> </tr> <tr> <td>Endocrine (Hormone) <input type="checkbox"/></td> <td>Liver Trouble <input type="checkbox"/></td> </tr> <tr> <td>Epilepsy <input type="checkbox"/></td> <td>Mumps <input type="checkbox"/></td> </tr> <tr> <td>Emotional Disorder <input type="checkbox"/></td> <td>Rheumatic Fever <input type="checkbox"/></td> </tr> <tr> <td>Excessive bleeding <input type="checkbox"/></td> <td>Speech Disorder <input type="checkbox"/></td> </tr> <tr> <td>Eye <input type="checkbox"/></td> <td>Tuberculosis <input type="checkbox"/></td> </tr> <tr> <td>AIDS <input type="checkbox"/></td> <td>Hepatitis <input type="checkbox"/></td> </tr> <tr> <td colspan="2">Other: _____</td> </tr> </table>	Asthma <input type="checkbox"/>	Fainting/dizziness <input type="checkbox"/>	Bone (fracture) <input type="checkbox"/>	Hearing <input type="checkbox"/>	Seizures <input type="checkbox"/>	Heart Trouble <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Kidney Trouble <input type="checkbox"/>	Endocrine (Hormone) <input type="checkbox"/>	Liver Trouble <input type="checkbox"/>	Epilepsy <input type="checkbox"/>	Mumps <input type="checkbox"/>	Emotional Disorder <input type="checkbox"/>	Rheumatic Fever <input type="checkbox"/>	Excessive bleeding <input type="checkbox"/>	Speech Disorder <input type="checkbox"/>	Eye <input type="checkbox"/>	Tuberculosis <input type="checkbox"/>	AIDS <input type="checkbox"/>	Hepatitis <input type="checkbox"/>	Other: _____	
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Other: _____																								
Does the patient have any history of major illness? _____	Yes <input type="checkbox"/> No <input type="checkbox"/>																							
Has the patient ever been under the care of a physician? _____	Yes <input type="checkbox"/> No <input type="checkbox"/>																							
Please list: _____																								
Has there been any injuries to the face, mouth, or teeth? _____	Yes <input type="checkbox"/> No <input type="checkbox"/>																							
Has the patient ever sucked a thumb or fingers? At what age? _____	Yes <input type="checkbox"/> No <input type="checkbox"/>																							
Does the patient have any speech problems? _____	Yes <input type="checkbox"/> No <input type="checkbox"/>																							
Is the patient a mouth breather? While awake? While asleep? _____	Yes <input type="checkbox"/> No <input type="checkbox"/>																							
Have you been informed of any missing or extra permanent teeth: _____	Yes <input type="checkbox"/> No <input type="checkbox"/>																							
Has either parent had orthodontic treatment? _____	Yes <input type="checkbox"/> No <input type="checkbox"/>																							
Has an orthodontist been consulted previously? _____	Yes <input type="checkbox"/> No <input type="checkbox"/>																							
Has the patient reached puberty? _____	Yes <input type="checkbox"/> No <input type="checkbox"/>																							
Girls - Has she started menstruation? At what age? _____	Yes <input type="checkbox"/> No <input type="checkbox"/>																							
Boys - Has his voice changed? At what age? _____	Yes <input type="checkbox"/> No <input type="checkbox"/>																							
Have tonsils and adenoids been removed? What age? _____	Yes <input type="checkbox"/> No <input type="checkbox"/>																							
Height _____ Weight _____																								
Do you have orthodontic insurance? Yes <input type="checkbox"/> No <input type="checkbox"/> Name of Company? _____																								
List any drugs or medications now being taken. Give reasons: _____																								
List any allergies or drug sensitivity: _____																								

CREDIT AUTHORIZATION: I hereby authorize OrthoBanc, LLC, on behalf of Dr. Aimee S. Skelton to obtain a copy of my credit report from a credit reporting agency for the purpose of considering payment options.

Applicant _____

Joint Applicant _____

To the best of my knowledge, the above information is complete and correct. I give my permission for any photographs, x-rays, or study models to be used for displays at scientific meetings, presentations and publications of a scientific nature or for study group purposes to further the art and science of orthodontics. I, the undersigned agree to pay for attorney fees and other costs of collection in the event it becomes necessary to use attorney services to secure payment of this account.

Signature (parent if patient is a minor) _____