

WELCOME TO OUR OFFICE !

Patient's Name: _____
Preferred Name: _____ Sex: _____ Age: _____ Date Of Birth: _____
Home Phone: _____ Cell Phone: _____ E-Mail: _____
Home Address/Mailing Address: _____
Patient's Dentist Name: _____ Did Dentist Refer You? _____
Date of Patient's Last Dental Check-Up/Cleaning _____
Who else may we thank for referring you to our office? _____
Names of other family members treated or seen by Dr. Stich: _____
Name of patient's school: _____ Grade Level: _____
Patient's interests or hobbies? _____
Is there any other information that may be helpful? _____
What would you like to see orthodontics accomplish? _____

HEALTH HISTORY

	Yes	No	
Is the patient in good health?	___	___	If no, reason: _____
Any major or unusual illnesses?	___	___	If yes, explain: _____
Currently taking medication?	___	___	If yes, please list: _____
Allergies?	___	___	If yes, please list: _____
Drug sensitivities?	___	___	If yes, please list: _____

Please check if patient has/had any of the following:

Yes	No	Yes	No	Yes	No
___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___

Growth Information for Patients Under 16 Years of Age:

Father's Height: _____ Mother's Height: _____ Adopted: ___ Yes ___ No
Girls: Has she started menstruation? ___ Yes ___ No When? _____ Boys: Has his voice changed? ___ Yes ___ No
Name and Birthdate of Patient's Brothers and Sisters: _____
Have any had Orthodontic Treatment? ___ Yes ___ No When? _____

DENTAL HISTORY

Yes	No	
___	___	Has the patient had any severe head or face injuries? Explain: _____
___	___	Has the patient had a history of thumb or finger sucking? Stopped when? _____
___	___	Has the patient consulted an orthodontist previously?
___	___	Has the patient had any previous orthodontic treatment? Explain: _____
___	___	Headaches (more than normal)
___	___	Jaw Joint Clicking/Popping
___	___	Clenching/Grinding
___	___	Jaw Joint Locking

PARENTAL INFORMATION

Mother's Name: _____ Date of Birth: _____
Mother's Address (only necessary if different from patient): _____
* _____
Mother's Phone #: _____ Work Phone #: _____
Social Security #: _____ Employer's Name: _____
Marital Status: ___ Married ___ Separated ___ Divorced ___ Widowed ___ Single

Father's Name: _____ Date of Birth: _____
Father's Address (only necessary if different from patient or different from mother's address listed above):
* _____
Father's Phone #: _____ Work Phone #: _____
Social Security #: _____ Employer's Name: _____

GUARDIAN INFORMATION (if applicable)

Guardian's Name and Address (address only necessary if different from patient): _____

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Relationship to Patient: _____

Home # (only if different from patient): _____ Work Phone #: _____

Social Security #: _____ Employer's Name: _____

EMERGENCY INFORMATION

Name and Phone #: _____

The above information is accurate and complete to the best of my knowledge. I understand, where appropriate, credit reports may be obtained if necessary for financial planning.

DATE: _____ SIGNATURE: _____

Responsible Party

Is patient covered by dental insurance? _____ If so, please complete the attached insurance form.