

3357 Merlin Dr.
Idaho Falls, ID 83404
(208) 522-9600



214 E. 1st North
Rexburg, ID 83440
(208) 356-3300

PATIENT INFORMATION

Name: _____ Sex: M F D.O.B.: _____
 First Middle Last Preferred Name
Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____
Phone: _____ Work Phone: _____ Email: _____

RESPONSIBLE PARTY INFORMATION

<input type="checkbox"/> Father	<input type="checkbox"/> Self	<input type="checkbox"/> Other	<input type="checkbox"/> Mother	<input type="checkbox"/> Spouse	<input type="checkbox"/> Other
Name: _____	Name: _____	Name: _____	Name: _____	Name: _____	Name: _____
First Middle Last	First Middle Last	First Middle Last	First Middle Last	First Middle Last	First Middle Last
Address: _____	Address: _____	Address: _____	Address: _____	Address: _____	Address: _____
Apt #: _____	Apt #: _____	Apt #: _____	Apt #: _____	Apt #: _____	Apt #: _____
City: _____	City: _____	City: _____	City: _____	City: _____	City: _____
State: _____	State: _____	State: _____	State: _____	State: _____	State: _____
Zip: _____	Zip: _____	Zip: _____	Zip: _____	Zip: _____	Zip: _____
Phone: _____	Phone: _____	Phone: _____	Phone: _____	Phone: _____	Phone: _____
Work Phone: _____	Work Phone: _____	Work Phone: _____	Work Phone: _____	Work Phone: _____	Work Phone: _____
Cell Phone: _____	Cell Phone: _____	Cell Phone: _____	Cell Phone: _____	Cell Phone: _____	Cell Phone: _____
Email: _____	Email: _____	Email: _____	Email: _____	Email: _____	Email: _____
D.O.B.: _____	D.O.B.: _____	D.O.B.: _____	D.O.B.: _____	D.O.B.: _____	D.O.B.: _____
Marital Status: _____	Marital Status: _____	Marital Status: _____	Marital Status: _____	Marital Status: _____	Marital Status: _____
Does this person live in same household as the patient? _____	Does this person live in same household as the patient? _____	Does this person live in same household as the patient? _____	Does this person live in same household as the patient? _____	Does this person live in same household as the patient? _____	Does this person live in same household as the patient? _____
S.S. # _____	S.S. # _____	S.S. # _____	S.S. # _____	S.S. # _____	S.S. # _____
Emergency Contact: _____	Emergency Contact: _____	Emergency Contact: _____	Emergency Contact: _____	Emergency Contact: _____	Emergency Contact: _____
Phone: _____	Phone: _____	Phone: _____	Phone: _____	Phone: _____	Phone: _____

EMPLOYER INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

No. Years Employed: _____ Occupation: _____

Insurance Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Ext: _____

Group #: _____ Policy #: _____

Orthodontic Coverage? Yes No Not Sure

EMPLOYER INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

No. Years Employed: _____ Occupation: _____

Insurance Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Ext: _____

Group #: _____ Policy #: _____

Orthodontic Coverage? Yes No Not Sure

OTHER INFORMATION

Dentist Name: _____	Who may we thank for referring you to our office? _____
Other Children: _____ Age _____	Other Children: _____ Age _____
_____ Age _____	_____ Age _____
_____ Age _____	_____ Age _____
_____ Age _____	_____ Age _____

MEDICAL INFORMATION

Yes No

- Any heart disease?
- Any respiratory disease?
- Any blood disease?
- Any broken bones?
- Any thyroid disease?
- Any kidney disease?
- H.I.V. positive?
- Any venereal disease?
- Any intestinal disease?
- Any bone disease?
- Allergic to anything?
- Any endocrine problems?
- Any prolonged bleeding?
- Does the patient bruise easily?
- Rheumatic/Yellow/Scarlet Fever?

Yes No

- Acquired Immune Deficiency Syndrome?
- Is patient under medical care?
- Any history of fainting or dizziness?
- Any nervous/emotional problems?
- Does the patient smoke?
- Any drug addiction?
- Is the patient pregnant at this time?
- Measles/Mumps/Chicken Pox?
- Is the patient in good health?
- Any high/low blood pressure?
- Any problems with wounds healing?
- Heart murmur/defect?
- Mononucleosis?
- Hepatitis?
- Emphysema?

Yes No

- Yellow Jaundice?
- Anemia?
- Polio?
- Epilepsy/seizures?
- Latex allergy?
- Fever blisters?
- Tuberculosis?
- Diabetes?
- Blood transfusions?
- Chemical dependence?
- Radiation therapy?
- Hemophilia?
- Asthma or hay fever?
- Any liver disease?
- Rheumatism or arthritis?
- Any tumors or cancer?
- Any condition needing MRI follow-up?

Explain any "yes" answers. _____

List any medications the patient is taking. _____

List any problems not mentioned above that we should know about. _____

DENTAL HISTORY

Yes No

- Has the patient seen a general dentist in the last year?
- Any pain, clicking, or discomfort in or near the patient's ears?
- Has the patient's mouth, face, or teeth been injured by a fall or accident?
- Have you been informed of missing or extra permanent teeth?
- Does the patient have any "gum" problems?
- Have the patient's tonsils or adenoids been removed?
- Is the patient happy with their "smile?"
- Does the patient want to improve their "smile?"
- Cheek, tongue, or lip chewing
- Thumb sucking

Yes No

- Mouth breathing
- Fingernail biting
- Clenching teeth
- Tongue thrusting
- Grind teeth
- Speech problems
- Ever been examined by an orthodontist before?
If yes, when? _____
- Have other members of the family had orthodontic treatment?

In your own words, what is the orthodontic problem? _____

What would you like orthodontic treatment to accomplish? _____

X _____
 Patient Signature

_____ Date

X _____
 Parent or Guardian Signature (if required)

FOR OFFICE USE ONLY

