

# MICHAEL A. BROWN, D.M.D., P.C.

## Orthodontics for Children and Adults

DATE: \_\_\_\_\_

### 1 PATIENT INFORMATION BEGIN HERE:

Name: _____	Address: _____
First            MI            Last            Nickname	
Phone: _____	Birthdate: _____
Age: _____	Sex: _____
City: _____	State: _____
ZIP: _____	

### 2 RESPONSIBLE PARTY INFORMATION BEGIN HERE:

<b>FATHER or SELF or GUARDIAN INFORMATION</b>
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
How long at this address: _____
Home Phone: _____ Work Phone: _____
Cell: _____ Email: _____
Birthdate: _____ Age: _____ Sex: _____ Marital Status: _____
Social Security Number: _____
Relationship to Patient: _____
<b>EMPLOYER INFORMATION</b>
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Occupation: _____
Number of Years Employed: _____
<b>INSURANCE COMPANY INFORMATION</b>
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Insurance Phone: _____ Ext: _____
Subscriber ID #: _____ Group #: _____

<b>MOTHER or SPOUSE INFORMATION</b>
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
How long at this address: _____
Home Phone: _____ Work Phone: _____
Cell: _____ Email: _____
Birthdate: _____ Age: _____ Sex: _____ Marital Status: _____
Social Security Number: _____
Relationship to Patient: _____
<b>EMPLOYER INFORMATION</b>
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Occupation: _____
Number of Years Employed: _____
<b>INSURANCE COMPANY INFORMATION</b>
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Insurance Phone: _____ Ext: _____
Subscriber ID #: _____ Group #: _____

### 3 OTHER INFORMATION:

Dentist's Name: _____	Names of children/siblings	Ages
Physician's Name: _____	1. _____	_____
School Name: _____	2. _____	_____
Sports or Hobbies: _____	3. _____	_____
Musical Instruments Played: _____	4. _____	_____
	Whom may we thank for referring you? _____	

## 4 MEDICAL INFORMATION

YES   NO		YES   NO		YES   NO		YES   NO	
Any Heart Disease:	_____	Acquired Immune Deficiency Syndrome:	_____	Heart Murmur:	_____	Asthma or Hay Fever:	_____
Any Respiratory Disease:	_____	Is Patient Under Medical Care:	_____	Mononucleosis:	_____	Tuberculosis:	_____
Any Blood Disease:	_____	Rheumatism or Arthritis:	_____	Hepatitis:	_____	Any Broken Bones:	_____
Any Liver Disease:	_____	Is the Patient Taking any Medications	_____	Polio:	_____	Prolonged Bleeding:	_____
Any Thyroid Disease:	_____	If yes, what: _____		Diabetes:	_____	Yellow Jaundice:	_____
Any Kidney Disease:	_____			Anemia:	_____	Radiation Therapy:	_____
Any Stomach Disease:	_____	History of Fainting or Dizziness:	_____	Hemophilia:	_____	Chemical Therapy:	_____
Any Venereal Disease:	_____	Does the Patient Have a Drug Addiction:	_____	Emphysema:	_____	Blood Transfusions:	_____
Any Intestinal Disease:	_____	Is the Patient Pregnant at this Time:	_____	Epilepsy:	_____	Allergies:	_____
Any Bone Disease:	_____	Measles/Mumps/Chicken Pox:	_____			If yes, what: _____	
Any Hearing Problems:	_____	Does the Patient Smoke:	_____				
Any Nervous/Emotional Problems:	_____	Is the Patient on a Diet:	_____				
High or Low Blood Pressure:	_____	Has the Patient Ever Had Fever Blisters:	_____			Is there any disease, condition, or problem not listed above that we should know about: _____	
Any Endocrine Problems:	_____	Is the Patient in Good Health:	_____			If yes, what: _____	
Any Problem with Wounds Healing:	_____	Is Height and Weight Normal for Age:	_____			_____	
Any Tumors or Cancer:	_____	Has the Patient had a Physical this Year:	_____			_____	
Rheumatic/Yellow/Scarlet Fever:	_____	Has the Patient Reached Puberty:	_____			_____	

## 5 DENTAL HISTORY

YES   NO		YES   NO		YES   NO	
Has the patient seen a general dentist in the last year:	_____	Does the patient have or ever had any of the following habits:			
Any pain, clicking, or discomfort in or near the ears:	_____	Cheek, tongue, or lip chewing:	_____	Grind teeth:	_____
Has the mouth, face, or teeth been injured by a fall or accident:	_____	Thumb sucking:	_____	Tongue thrusting:	_____
Have you been informed of missing or extra permanent teeth:	_____	Mouth breathing:	_____	Speech problems:	_____
Are you aware of any "gum" problems:	_____	Fingernail biting:	_____	Has the patient been examined by an orthodontist before:	_____
Has a physician or dentist advised antibiotics before a dental exam:	_____			If yes, when: _____	
Have the patient's tonsils or adenoids been removed:	_____	Have other family members had orthodontic treatment:	_____	If yes, were you happy with the results:	_____
Do you feel the patient can benefit from orthodontic treatment:	_____			If no, why: _____	
Is the patient happy with their "SMILE":	_____				
Does the patient want to improve their "SMILE" and "BITE":	_____				
Does the patient mind wearing "BRACES":	_____				
In your own words, what is the orthodontic problem: _____					
What would you like orthodontic treatment to accomplish: _____					

## 6 RELEASE

I understand that where appropriate a credit report may be obtained.  
I authorize and request my insurance company to pay directly to the orthodontist insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

I attest to the accuracy of information on the front and the back of this page.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Signature