-Welcome-

We would like to welcome you and your child to our office. In order to provide excellent service, we ask you to fill out this form as completely as possible. Thank you for your cooperation.

Patient Information – Adult

Name_____ **Birth Date**: _____/_____/_____
(First) (Middle) (Last) (Nickname)

Age: _____ **Male** **Female** **Best Phone number**: (_____) _____HM/CELL/WK

Email: _____

Home Address: _____
(Street) (City) (State) (Zip)

SSN:_____ **Employer:**_____**Occupation:**_____

General Dentist: _____ **How did you hear about our office?**_____

Have we treated another member of your family? Yes No If yes, name: _____

What are the main concerns that you would like orthodontics to address?

_____

Have you visited an orthodontist before? Yes No If yes, for what reason: _____

Primary Billing Party (if different from above)

Self Mother Stepmother Father Stepfather Spouse Guardian

Name:_____**Email Address:** _____

Address (If different):_____
(Street) (City) (State) (Zip)

Home Phone: (_____) _____ **Cell Phone:** (_____) _____ **Employer:**_____

Occupation:_____ **SSN:**_____**DOB:**_____

Primary Insurance Information

Policy Holder Name : _____ **Relationship to patient:**_____

DOB: _____ **SSN:** _____**Ins. Co. Name:**_____

Ins. Phone #: _____ **ID #:** _____ **Group #:** _____

Insurance Address: _____
(Street) (City) (State) (Zip)

Medical Information

Physician: _____ Phone Number: _____
History of major illness? Yes No If yes, please describe:_____
Is your child currently under the care of a physician: Yes No If yes, for what reason: _____
Taking Medication: Yes No If yes, please list: _____
Allergic to any Medication: Yes No If yes, please list: _____
Allergic to anything else: Yes No If yes, please list: _____
Has/Had or Have any: (circle all that apply)

Anemia	Convulsions	Hyperactivity	Rheumatic Fever
Arthritis	Diabetes	Illness in Infancy	Sickle Cell Anemia
Asthma	Emotional Problems	Learning Difficulty	Speech Impediment
AIDS/HIV	Epilepsy/Seizures	Liver Disease	Surgery
Birth Defects	Heart Disorder	Mental Disorder	Tuberculosis
Bleeding Issues	Hepatitis	Milk Allergy	Tumors/Cancer
Chronic Illness	Hospitalization	Osteoporosis	

Please explain any other problems: _____
_____
_____

Dental Information

Last Dental Visit: _____
Please list any concerns you have about the health and/or appearance of your teeth:
_____
Any previous dental care: Yes No What for: _____

Is there now or has there ever been any of the following: (circle all that apply)

Braces	Gum Disease	Missing or extra teeth	Thumb Sucking
Cavities	Injured Teeth	Oral Habits	Toothache
Extracted Teeth	Lip Biting/ Sucking	Pain of the TMJ	Unfavorable Experiences

Explain any issues:
_____

Signature

I understand that the information I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

I hearby authorize release of any information related to insurance claims. I consent to examination and treatments from the office of Dr. Brian St. Louis.

Signature: _____ Date: _____

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