

Date _____

Confidential Responsible Party Information

Pt. Chart # _____ A B C

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Name _____ Marital Status _____
Last First Middle

Residence _____ Own Rent
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Previous Address _____
Street City State Zip # of years

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____ Cell Phone _____

Confidential Patient Information

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Social Security # _____

Cell Phone _____ Email _____

If patient is a minor, give parents or guardian's name _____

School _____ Grade _____ Hobbies _____ Dentist _____

Whom may we thank for referring you to our office? _____

Insurance Information

Policy Holder's Name _____ and Soc. Sec. # _____

Insurance Company _____ Group No. _____ Policy No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____ Policy Holders Date of Birth _____

Do you have dual coverage? No Yes If yes:

Policy Holder's Name _____ and Soc. Sec. # _____

Insurance Company _____ Group No. _____ Policy No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____ Policy Holders Date of Birth _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship: _____

I understand that where appropriate, credit bureau reports will be obtained.

Signature (Parent's signature if minor) **X** _____

Updates (date & initial) _____



John R. St. Clair, D.D.S., M.S., P.A.
 James T. St. Clair, D.D.S., M.S., P.A.
 Orthodontics for Adults and Children

5203 79th Street, Suite H • Lubbock, Texas 79424

Reviewed with patient by _____
 Date _____

Medical History

Physician _____ Date of last visit _____
 Address _____ Phone _____

Please circle Yes or No (if Yes, please fill in details)

- Yes No Are you taking any medication? _____
- Yes No Are you allergic to any medication? _____
- Yes No Do you have a history of a major illness? _____
- Yes No Have you had any major operations? _____
- Yes No Have you ever been involved in a serious accident? _____

Circle any of the medical conditions below that you have had or currently have.

- | | | | |
|------------------------------|----------------------------|--------------------------|-------------------------|
| Abnormal bleeding/Hemophilia | Diabetes | Hepatitis/Liver Problems | Pneumonia |
| Anemia | Dizziness | Herpes | Prolonged Bleeding |
| Arthritis | Epilepsy | High Blood Pressure | Radiation/ Chemotherapy |
| Asthma or Hayfever | Gastrointestinal Disorders | HIV +/- AIDS | Rheumatic Fever |
| Bone Disorders | Heart Problems | Kidney Problems | Tuberculosis |
| Congenital Heart Defect | Heart Murmur | Nervous Disorders | Tumor or Cancer |

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

Dental History

Dentist _____ Date of last visit _____
 Address _____ Phone _____

What concerns you most about your teeth? _____

- Yes No Are you presently in any dental pain? _____
- Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
- Yes No Have you ever lost or chipped any teeth? _____
- Yes No Have there been any injuries to face, mouth or teeth? _____
- Yes No Is any part of your mouth sensitive to temperature or pressure? _____
- Yes No Do your gums bleed when you brush? _____
- Yes No Do you have any type of thumb or tongue habit? _____
- Yes No Are you a mouth breather? _____
- Yes No Have you ever seen an orthodontist? _____
- Yes No Has anyone in the family received orthodontic treatment? _____
 How did they feel about the result? _____
 What is your attitude about receiving orthodontic treatment? _____
- Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
- Yes No Are you aware of your jaw clicking or popping? _____
- Yes No Are you aware of clenching your teeth during the day? _____
- Yes No Have you ever been told that you grind your teeth? _____
- Yes No Do you have 'tension' headaches? _____
- Yes No Have you ever experienced chronic ringing in your ears? _____
- Yes No Are you aware that some appointments will be during school/work hours? _____

Benefits or Orthodontics

AESTHETICS, HEALTH, AND FUNCTION

Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment.

I have read and understand the above paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history.

 Patient/Parent

 Date