



Date _____
Patient's Name _____ Sex _____ Date of Birth _____
Age _____ Social Security Number _____ Nickname _____
Home Phone _____ Cell Phone _____ Email _____
Marital Status ___ Married ___ Divorced ___ Widowed ___ Single
Whom may we thank for recommending our office to you? _____
Who is your dentist? _____ Date of Last Cleaning _____
Occupation _____ Employer _____
Business Address _____ Phone _____
Name of Spouse _____ Occupation _____
Employer _____ Business Address _____
Name of Person Responsible for Account _____ SSN _____
Address and Phone # of Responsible Party if not listed above _____

Do you have Orthodontic Insurance? ___ Yes ___ No
Name of Insurance Company _____ Phone # _____
Name of Insured _____ SSN _____ DOB _____
Member ID # _____ Group Policy # _____

*Mountain Orthodontics Is Out Network for ALL Insurances. Patient is responsible for knowledge of benefits and if predetermination is required _____ (initial)

MEDICAL HISTORY:

Are you in good health? ___ Yes ___ No Do you have any history of major illness? ___ Yes ___ No
Have you been under care of a physician for illness? ___ Yes ___ No
If yes, please explain _____

CHECK ANY OF THE FOLLOWING FOR WHICH YOU HAVE BEEN TREATED:

___ Diabetes ___ Tuberculosis ___ Endocrine Problems ___ Nervous Disorders
___ Pneumonia ___ Anemia ___ Prolonged Bleeding ___ Liver Involvement
___ Heart Trouble ___ Epilepsy ___ Fainting or Dizziness ___ HIV/AIDS
___ Rheumatic Fever ___ Asthma ___ Bone Disorders ___ Cancer

Have tonsils and/or adenoids been removed? ___ Yes ___ No At what age _____

Do you snore or have sleep apnea? ___ Yes ___ No

List any medication and supplements being taken _____

List any allergies or drug

sensitivities_____

Any injuries to face, mouth or teeth?___Yes___No

Missing or extra permanent teeth?___Yes___No

Has an orthodontist been consulted previously?___Yes___No

Reason for appointment?_____

Patient (Print)

Patient (Signature)