



## PATIENT INFORMATION

Patient's Last Name		Patient's First Name		Patient's Preferred Name (Nickname)		M / F	
Patient's DOB	Patient's Age	Patient's Email Address		Patient's Social Security #			
Patient's Street Address		Patient's City, State, Zip		Patient's Landline #	Patient's Cell #		
Any other family members treated here? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, who?					
Other Sibling/Child Full Name		M / F	Sibling/Child DOB	Other Sibling/Child Full Name		M / F	Sibling/Child DOB
Patient's Dentist				Date of last dental cleaning			
Whom may we thank for referring you to our office?				If patient is a minor, parent or guardian's name			

## RESPONSIBLE PARTY INFORMATION

Resp. Party's Last Name		Resp. Party's First Name		Resp. Party's Email Address		Relationship to Patient		
Resp. Party's Street Address (if different from patient address)		Resp. Party's City, State, Zip		Resp. Party's Landline #		Resp. Party's Cell #		
How long at this address?	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated			Resp. Party's Social Security #				
Previous Street Address (if less than 3 years at current address)				Previous City, State, Zip				
Resp. Party's Employer		Resp. Party's Occupation		# Yrs at Employer		Resp. Party's DOB		
Resp. Party's Spouse/Partner Name		Spouse/Partner Relationship to Patient		Spouse/Partner Employer		Spouse/ Partner Occupation		# Yrs at Employer
Spouse/Partner DOB		Spouse/Partner Social Security #		Spouse/Partner Cell #		Spouse/Partner Work #		

## PRIMARY DENTAL INSURANCE INFORMATION

Subscriber's Last Name		Subscriber's First Name		Subscriber's Relationship to Patient		Subscriber's DOB	
Insurance Company's Name		Insurance Company's Phone #		Subscriber's Member #		Subscriber's Group #	

## EMERGENCY INFORMATION (RELATIVE/FRIEND NOT LIVING WITH YOU)

Emergency Contact's Name		Emergency Contact's Street Address		City, State, Zip	
Relationship to Patient		Emergency Contact's Landline #		Emergency Contact's Cell #	

Please continue on back

Has an orthodontist been previously consulted?

Yes  No

Are antibiotics necessary for dental cleanings?

Yes  No

Has patient ever taken bisphosphonates (Aredia, Zometa, Fosamax, Actonel or Boniva)?

Yes  No

List any drugs/things patient is allergic to or has a reaction to:

List any medications patient is currently taking:

Physician's Name:

What is your dentist's main orthodontic concern?

Is there any dental work needing to be completed prior to orthodontic treatment?  Yes  No

If yes, please explain:

Is patient under the care of a physician at this time?

Yes  No

If yes, please explain:

Indicate patient's feeling toward orthodontic treatment:

- Excited to get started
- Complacent
- Not Committed

Indicate patient's reasons for seeking orthodontic treatment:

- Esthetics
- Dental Function
- Overall Health

Please describe any orthodontic concerns and what you would like accomplished:

Personality Assessment (Please check all that describe patient)

- Nervous  Outgoing  Serious
- Calm  Uncooperative  Humorous
- Confident  Sensitive  Cooperative
- Shy  Afraid  Independent

Does patient have clicking, popping or pain in jaw joints?  Yes  No

If yes, which sides, since when and during what activity?

### CHECK YES OR NO IF PATIENT CURRENTLY HAS OR HAS HAD:

Adenoids/ tonsils abnormal	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Has patient reached puberty?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Adenoids/ tonsils removed	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophiliac	<input type="checkbox"/> Yes <input type="checkbox"/> No	Abnormal height or weight?	<input type="checkbox"/> Yes <input type="checkbox"/> No
ADD/ ADHD	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient adopted?	<input type="checkbox"/> Yes <input type="checkbox"/> No
AIDS/ HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	If adopted, does he/she know?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy/ sinus trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	High/ low blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Food allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Latex allergy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial heart valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nickel allergy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle/ joint problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is bite uncomfortable?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Autism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Organ transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any facial injuries?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bone disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Trauma to the jaw?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Physical disabilities	<input type="checkbox"/> Yes <input type="checkbox"/> No	Trauma to any teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Clenching teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation/ chemo / blood therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Missing/extra permanent teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic/ scarlet/ yellow fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Down syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scoliosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cheek, tongue or lip chewing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Finger/ thumb/ lip sucking?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ear problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fingernail habit?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Endocrine problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	TMJ problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty breathing thru nose?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Faintness/ dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Snore while sleeping?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fever blisters	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Speech problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headaches (frequent)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whiplash	<input type="checkbox"/> Yes <input type="checkbox"/> No	Strong gag reflex?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Wound healing problems	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Please explain ANY medical or dental conditions not mentioned above:

### PATIENT CONSENT

The undersigned hereby authorizes Dr. Jeremy Sayre and the staff of Sayre Orthodontics to take x-rays, study models, photographs and an orthodontic examination in order to make a thorough diagnosis of the patient's orthodontic needs. It is my responsibility to inform this office immediately of any changes in any medical status. I understand that when appropriate credit bureau reports may be obtained.

Patient or responsible party signature ( if patient is under 18 yrs old )

Date