



**PATIENT INFORMATION FORM**

**PATIENT INFORMATION**

Name \_\_\_\_\_ Nickname \_\_\_\_\_ M/F Age \_\_\_\_ Birthdate \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_  
 Name & Age of Siblings \_\_\_\_\_  
 Patient's School \_\_\_\_\_  
 If patient is a college student, please provide a residence address \_\_\_\_\_  
 \_\_\_\_\_  
 Whom may we thank for referring you to our office? \_\_\_\_\_

**PARENT'S/GUARDIAN'S INFORMATION**

Father's Name \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Mother's Name \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

Person responsible for account \_\_\_\_\_  
 Billing address \_\_\_\_\_  
 Relationship to patient \_\_\_\_\_

**EMERGENCY CONTACT**

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 Complete Address \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

The office of Dr. Brady will be happy to process your orthodontic claims.  
**To successfully process your claims, all of the following information is necessary.**  
 If you do not have all of the required information we suggest you contact your Human Resources Representative and they can help you with any missing information.

**DENTAL INSURANCE INFORMATION**

<b>Primary Insured's Name</b> _____	<b>Insured's Date of Birth</b> _____
<b>Insurance Co.</b> _____	<b>Soc. Sec. No.</b> _____
<b>Insurance Co. Address</b> _____	<b>Phone</b> _____
<b>Insured's Employer</b> _____	<b>Group No.</b> _____

I hereby authorize release of any information relating to my insurance.  
 Signature: \_\_\_\_\_ Date \_\_\_\_\_  
 I hereby authorize payment of insurance benefits directly to the named orthodontists.  
 Signature: \_\_\_\_\_ Date \_\_\_\_\_  
 Dual Insurance (if applicable)

<b>Secondary Insured's Name</b> _____	<b>Insured's Date of Birth</b> _____
<b>Insurance Co.</b> _____	<b>Soc. Sec. No.</b> _____
<b>Insurance Co. Address</b> _____	<b>Phone</b> _____
<b>Insured's Employer</b> _____	<b>Group No.</b> _____





Patient's Name \_\_\_\_\_

### DENTAL HISTORY

Patient's Dentist \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Complete address \_\_\_\_\_

1) Have you previously consulted an orthodontist? \_\_\_\_\_ Yes \_\_\_ No\_\_\_

If Yes, when? \_\_\_\_\_

2) Is there a family history of congenitally missing teeth? \_\_\_\_\_ Yes \_\_\_ No\_\_\_

Yourself \_\_\_\_\_ Relative(s) \_\_\_\_\_

3) Do your gums bleed when you brush your teeth? \_\_\_\_\_ Yes \_\_\_ No\_\_\_

4) Is any part of your mouth sensitive to temperature? \_\_\_\_\_ Yes \_\_\_ No\_\_\_

Is any part of your mouth sensitive to pressure? \_\_\_\_\_ Yes \_\_\_ No\_\_\_

5) Have you ever sucked your thumb or finger(s)? \_\_\_\_\_ Yes \_\_\_ No\_\_\_

If so, have you stopped this habit? \_\_\_\_\_ When? \_\_\_\_\_

6) Do you breathe predominantly through your mouth? \_\_\_\_\_ Yes \_\_\_ No\_\_\_

7) Have you had tonsils/adenoids removed? \_\_\_\_\_ Yes \_\_\_ No\_\_\_

If Yes, when? \_\_\_\_\_

8) Do you clench or grind your teeth during the day? \_\_\_\_\_ Yes \_\_\_ No\_\_\_

9) Have you been made aware of clenching or grinding your teeth during the night? \_\_\_\_\_ Yes \_\_\_ No\_\_\_

10) Do you now have, or have you ever had, pain in your jaw joint or the sides of your

face (in and about the ears)? \_\_\_\_\_ Yes \_\_\_ No\_\_\_

11) Have you ever had clicking or popping in your jaw joint? \_\_\_\_\_ Yes \_\_\_ No\_\_\_

If Yes, please explain \_\_\_\_\_

12) Have you ever experienced pain when you open wide? \_\_\_\_\_ Yes \_\_\_ No\_\_\_

13) Have you had any injury to your jaw? \_\_\_\_\_ Yes \_\_\_ No\_\_\_

If Yes, please explain \_\_\_\_\_

14) Have you had any injury to your teeth? \_\_\_\_\_ Yes \_\_\_ No\_\_\_

If Yes, please explain \_\_\_\_\_