CRIST ORTHODONTICS

PATIENT INFORMATION

Patient's Name _____
Last First Middle Nickname

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Age _____ Social Security # _____

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

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

Friends or family treated by Dr. Crist _____

RESPONSIBLE PARTY INFORMATION

Name _____ Marital Status _____
Last First Middle

Address _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Social Security # _____ Birthdate: _____ Relationship to patient _____

Email: _____

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 _____

INSURANCE INFORMATION

Insured's Name _____ Insured's Soc. Sec. #/I.D.# _____

Insurance Company _____ Group # _____ Local # _____

Ins. Claims Address _____
Street City State Zip

Do you have dual coverage? YES ☐ NO ☐ If yes, complete the following:

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance company _____ Group # _____ Local # _____

Ins. Claims Address _____
Street City State Zip

Insured's Employer _____

CONTINUED ON BACK

EMERGENCY INFORMATION

Name of close friend or relative not living with you_____Phone_____

Complete Address_____

MEDICAL HISTORY

Physician_____Phone_____

Address_____

☐ Yes ☐ No Are you taking any medications? _____

☐ Yes ☐ No Have you had any major illnesses or operations? _____

☐ Yes ☐ No Do you have frequent colds, sinus problems or tonsillitis? _____

☐ Yes ☐ No Are you pregnant? _____

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

Allergy	Arthritis	Convulsions	Dizziness	Hepatitis	Tuberculosis
Anemia	Asthma	Diabetes	Heart Problems	High Blood Pressure	Prolonged Bleeding

Are there any medical conditions we have not discussed that you feel we should know about?_____

DENTAL HISTORY

Dentist_____Date of last visit_____Phone_____

Address_____Date of last Dental x-ray_____

What concerns you most about your teeth?_____

☐ Yes ☐ No Have you ever had any severe dental or facial injury?_____

☐ Yes ☐ No Have you had any periodontal (gum) problems or bleeding?_____

☐ Yes ☐ No Have you ever had any popping or clicking of your jaw joints? _____

☐ Yes ☐ No Have you had pain, stiffness or locking of your jaw joints ?_____

☐ Yes ☐ No Do you grind or clench your teeth? _____

☐ Yes ☐ No Do you suck your thumb? _____

☐ Yes ☐ No Do you have a tongue thrust?_____

☐ Yes ☐ No Do you have any breathing problems?_____

☐ Yes ☐ No Do you play a musical instrument with a mouth piece?_____

☐ Yes ☐ No Do you breathe primarily through your mouth?_____

☐ Yes ☐ No Do you have any speech problems?_____

☐ Yes ☐ No Have you had a previous orthodontic consultation?_____

☐ Yes ☐ No Have you had previous orthodontic treatment?_____

☐ Yes ☐ No Has anyone in your family received orthodontic treatment?_____

☐ Yes ☐ No Have you had any primary (baby) teeth or permanent teeth removed?_____

Classify the patient's expressed desire for improving dental appearance:

☐ Very desirous ☐ Average desire ☐ Casual desire ☐ Objects

What would you most like to have orthodontic treatment accomplish?_____

_____

_____

_____ _____

Patient/Parent Date