Date: ______________________

ORTHODONTIC PATIENT HISTORY

PATIENT INFORMATION

Name: ____ Date of Birth: ____/____/____ Sex: M F
(Last) (First) (Nickname)

Names of Parents (if applicable): ____

Address: ____
(Street) (City) (State) (Zip)

Home Phone: ______________ Cell Phone: ______________ E-mail: ______________

School: ______________________________ Hobbies: ______________________________

Name of General Dentist to inform of Treatment Plan: ______________________________

Who may we thank for referring you to Dr. Paschen? ______________________________

Do you play a musical instrument? Yes No **Type of instrument** ______________________________

How did you hear about our office (check all that apply): ____Dentist ____Friend ____Co-worker ____Phone Book

____Internet Search ____Our Website ____Postcard ____Other: ______________________

PATIENT DENTAL HISTORY

Do you have any family members who have had orthodontics? ___Father ___Mother ___Brothers ___Sisters ___Children

(Please Mark if Applicable) ____Teeth sensitive to hot/cold ____Bleeding gums, bad taste in mouth

Do you have allergies? Yes No **Describe:** ______________________________

Do you snore at night? Yes No **Have your ____Tonsils and/or ____adenoids been removed?**

Date of most recent dental exam ______________________

How often do you brush your teeth? ______________ **How often do you floss your teeth?** ______________

How motivated are you to start orthodontic treatment? ______________

What is the main thing you would like to find out by coming to see Dr. Paschen, and what would you like to change about your smile? ______________________________

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RESPONSIBLE PARTY INFORMATION

Name ____ Date of Birth: ____/____/____

Address: ____
(Street) (City) (State) (Zip)

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Relationship to Patient: ______________________ E-mail: ______________________

DENTAL INSURANCE INFORMATION

Please complete only if you have Employer sponsored DENTAL coverage or REIMBURSEMENT Plans.

Subscriber Name: ____ Date of Birth: ____/____/____

Address: __________________________________ Social Security #: _________________________

Insurance Name: ____

Insurance Address:____

Insurance Phone Number:______________________ Type of Coverage: Individual ____ Family ____

Subscriber Number if Different from Social Security #__________________________________

Group # ________________________ Employer ____

If spouse also has coverage:

Subscriber Name: ____ Date of Birth: ____/____/____

Address: __________________________________ Social Security #: _________________________

Insurance Name: ____

Insurance Address:____

Insurance Phone Number:______________________ Type of Coverage: Individual ____ Family ____

Subscriber Number if Different from Social Security #__________________________________

Group # ________________________ Employer ____