

Date: _____

Confidential Responsible Party Information

Name: _____ Gender: M / F Marital Status: _____
Last First Middle

Residence: _____ Own: _____ Rent: _____
Street City State Zip

Billing Address: _____
Street City State Zip

How long at this address: _____ Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____ **Appt. Reminder: Text / Email / Both**

Social Security No.: _____ Birthdate: _____ Relationship to Patient _____

Employer: _____ Occupation: _____ Military Pay Grade: _____ No Years Employed: _____

Spouse's Name: _____
Last First Middle

Cell Phone: _____ Email: _____ **Appt. Reminder: Text / Email / Both**

Social Security No.: _____ Birthdate: _____ Work Phone: _____

Employer: _____ Occupation: _____ Military Pay Grade: _____ No Years Employed: _____

Confidential Patient Information Check this box if same as above

Name: _____ Social Security No.: _____
Last First Middle

Residence: _____
Street City State Zip

Home Phone: _____ Birthdate: _____

Employer: _____ Occupation: _____ Military Pay Grade: _____ No Years Employed: _____

Insurance Information

Policy Holder's Name: _____ D.O.B.: _____ Social Security No.: _____

Insurance Company: _____ ID No: _____ Group No.: _____

Insurance Company Address: _____ Insurance Co. Phone: _____

Policy Holder's Employer: _____

Do you have dual coverage?: Yes / No If yes, Policy Holder's Name / Employer: _____

Insurance Company: _____ ID No: _____ Group No.: _____

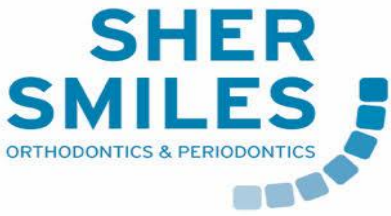
Insurance Company Address: _____ Insurance Co. Phone: _____

Emergency Contact Information

Name of Emergency Contact: _____ Relationship: _____

Address: _____ Phone: _____
Street City State Zip

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



Adult Patient Dental History Information

What is your main orthodontic problem(s)? _____

Are you sensitive about the appearance of your teeth or facial features (nose, chin, lips, etc)? _____

Are you interested in Traditional Braces? _____

Have you had an orthodontic consultation? Yes _____ No _____ If yes, when? _____

Has anyone in the family received orthodontic treatment from Sher Smiles? Yes _____ No _____

If yes, who? _____

Name of your current general dentist: _____ How many years? _____

Frequency of dental checkups? _____ Date of last dental exam: _____

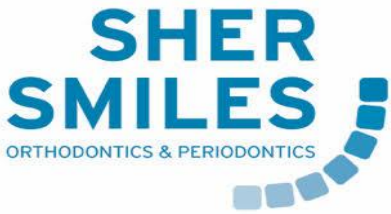
Are there any needed restorations? Yes _____ No _____

Date restorations will be completed? _____

Please check any of the following that apply and explain in the box below:

- Are you apprehensive about dental care?
- Have you had any trouble associated with dental treatment?
- Have you had any teeth extracted?
- Have you injured or broken any teeth?
- Do you have any discomfort from teeth?
- Do you have any missing teeth?
- Do you have any extra teeth?
- Do you receive regular fluoride treatment?
- Do you have discomfort from gums?
- Are you aware of any swellings or growth in your mouth?
- Do you have frequent canker sores
- Have you had any injuries to either jaw?
- Do you chew on objects such as pens?
- Do you have regular jaw pain?
- Do you have limited jaw movement?
- Do your jaws click or pop?
- Do you have any trouble eating, chewing or swallowing?
- Do you habitually grind or clench teeth?
- Are you in speech therapy currently?
- Have you had any injuries to you face or mouth?
- Do you breathe with your mouth open or lips parted?

If you have checked any of the above, please explain:



Adult Patient Medical History Information

Name & Location of Physician: _____

Are you in good health? _____ Date of last physical: _____

Are you presently under the care of a physician for any illness? _____ Please specify below.

Do you have a history of major illness or been hospitalized? _____ Please specify below

Is there anything you would like to talk to the doctor about in private? _____

Please check any of the following that apply and explain in the box below:

- Have you seen a medical specialist?
- Do you have a tendency to catch colds?
- Do you have an allergy to latex?
- Do you have an allergy to metals?
- Do you have any drug allergies / sensitivities?
- Do you require pre-medications?
- Are you taking any drugs or medications?
- Have you ever received Bisphosphonate treatment or other bone building medications? (e.g. Fosamax, Actinol, Bonival)
- Do you have gastric reflux?
- Are you pregnant or breastfeeding?

Please check any of the following for which the patient has been treated and explain in the box below:

- AIDS / HIV
- Asthma
- Arthritis
- Artificial joints
- Bone disorders
- Cancer
- Cerebral Palsy
- Diabetes
- Emotional disorder
- Endocrine problems
- Fainting or dizziness
- Frequent headaches or neck aches
- Heart trouble, defect or murmur
- Hepatitis
- Hormone Therapy
- Jaundice
- Kidney problems
- Liver problems
- Low / High blood pressure
- Multiple Sclerosis
- Nervous disorder
- Osteoporosis
- Prolonged bleeding
- Rheumatic Fever
- Sickle Cell Anemia
- Sleep Apnea / Snoring
- Stomach ulcers
- Tuberculosis
- Thyroid problems
- Unusual growth patterns

If you have checked any of the above, please explain:

I authorize the release of any necessary dental or medical records to Sher Smiles for this patient. Records may be discussed with other health care providers and / or for educational purposes. I understand that where appropriate, credit bureau reports may be obtained.

Signature of Responsible Party _____ Date" _____