



BRIAN J. EMRICH DDS • MSD

Specialist in Orthodontics for Children and Adults

PATIENT INFORMATION FORM

Welcome to our office . . .

Please assist us by completing the following questions . . .

Date of Exam _____

Date of Birth _____

Patient's Name _____ Prefers to be called _____ M F Age _____

Home Address _____ City _____ Zip _____

Phone _____ School _____ Grade _____

Names of Siblings (Ages) _____ Interests/Hobbies _____

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

Physician _____ Has any member of your family been treated in our office? Name _____

ORTHODONTIC CONSIDERATIONS

Yes	No	Date of last complete dental examination _____
<input type="checkbox"/>	<input type="checkbox"/>	Has the patient ever sucked their thumb or fingers? Until what age? _____
<input type="checkbox"/>	<input type="checkbox"/>	Does the patient breathe predominately through the mouth?
<input type="checkbox"/>	<input type="checkbox"/>	Has the patient had any clicking or discomfort in jaw joints?
<input type="checkbox"/>	<input type="checkbox"/>	Does the patient clinch or grind teeth (at night)?
<input type="checkbox"/>	<input type="checkbox"/>	Have you been informed of any missing or extra permanent teeth?
<input type="checkbox"/>	<input type="checkbox"/>	Has any member of the family had orthodontic treatment?
		Who? _____
<input type="checkbox"/>	<input type="checkbox"/>	Has the patient been examined by an orthodontist before?
		By Dr. _____ Date _____
		Why are you seeking an orthodontic consultation?
		Appearance <input type="checkbox"/> Function <input type="checkbox"/> Psychological <input type="checkbox"/> Other _____

HEALTH HISTORY

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Has the patient ever had any reaction to drugs or medication?
		Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Is the patient taking any drugs or medication presently?
		Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Does the patient have any allergies? List _____
<input type="checkbox"/>	<input type="checkbox"/>	Has the patient ever had any heart problems that require any premedication?
		Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Have patient's tonsils or adenoids been removed? What age? _____
<input type="checkbox"/>	<input type="checkbox"/>	Does patient suffer from an immuno depressive disease?
<input type="checkbox"/>	<input type="checkbox"/>	Has the patient ever had any of the following illnesses?
		Rheumatic fever, Prolonged bleeding, Asthma, Diabetes, Epilepsy, Heart trouble, Hepatitis, Arthritis, Anemia, Tuberculosis, Emotional problems, Mental retardation, Thyroid or Hormonal imbalance or any other serious medical problems?
		If yes to any, please circle and explain _____

RESPONSIBLE PARTY AND INSURANCE INFORMATION

	FATHER	MOTHER
Name	_____	_____
Home Address	_____	_____
Telephone #	_____	_____
Occupation	_____	_____
Employer	_____	_____
Business Phone #	_____	_____
Social Security Number	_____	_____
Birthdate	_____	_____
Name of Insurance Co.	_____	_____
Do you have orthodontic insurance coverage?	_____	_____
Person responsible for account: Father <input type="checkbox"/> Mother <input type="checkbox"/> Guardian <input type="checkbox"/>	Marital Status: _____	

I affirm the accuracy of the above and have received a copy of our office's "Notice of Privacy Practices"

Signature of Parent or Guardian _____ Date _____ 5/09