Patient Information

Date_____________________________

Patient's____
Last First Middle

Address____
Street City State Zip

Home Phone______________________ Birthdate__________ Social Security #_________________________

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

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

Responsible Party Information

Name ____ _____________
Last First Middle Marital Status

Residence____
Street City State Zip

Mailing Address ____
Street City State Zip

How long at this address?________________Home #_____________________ Work #____________________

Cell Phone #______________________________ Email Address ____

Previous address (If less than 3 years)____
Street City State Zip

Social Security #__________________ Birthdate_______________ Relationship to patient_________________

Employer____________________________Occupation__________________ # of Years Employed__________

Spouse's Name____ Relationship to Patient___________
Last First Middle

Employer_______________________________Occupation_______________ # of Years Employed___________

Social Security # _____________________________ Birthdate___________Work #_______________________

Insurance Information

Insured's Name _______________________________________ Insured's SS #__________________________

Insurance Company____________________________Group #___________Ins Co. Phone # ________________

Insurance Co.address____

Do you have dual coverage? ____Yes _____No If yes:

Insured's Name______________________________________ Insured's SS #__________________________

Insurance Company ______________________ Group #________ Ins Co. Phone #________________________

Insured's Employer____

Emergency Contact Information (other than responsible parties)

Name____Relation____________________

Complete Address ____

Phone #____

I understand by signing below I am authorizing a credit file to be processed by Experian.

Signature (Parent's signature if minor)________________________________

CHRIS CRUZ, D.D.S.
CHILD GET ACQUAINTED QUESTIONNAIRE

Sex:_____ Age:______ Birthdate:___________ Height: __________ Weight: ______

Ethnicity : Anglo American____African American____American Indian_____
Asian_____ Chinese____ Japanese_____ Korean____ Pacific Islander____ Latin____
We need ethnicity information for diagnosis purposes only.

School: ______________________ Grade: ____ Scholastic Performance:__________
Like or dislike school? ____
Had unfavorable reaction to dental care? _____________________________________
Reason for consultation? ____
Does patient desire orthodontic treatment? ___________________________________

GENERAL HEALTH
Any history of (circle the condition): Heart trouble, heart murmur, rheumatic fever, allergies, hepatitis, positive HIV, diabetes, asthma, kidney or liver involvement, epilepsy, bleeding disorders, mental disorders, etc.?_____________________________________
____
Has patient had any operations?____

Is patient presently taking any medications? (Rx, over the counter or herbal) __________
____
Have you ever had an allergic reaction to any medications? ______________________

If so, what medications? ____

Is patient sensitive to latex? ____

Has it ever been recommended that the patient take antibiotics prior to dental procedures?
____
Any previous orthodontic treatment? ____
Accidents/Trauma to mouth or teeth? ____
ORAL HABITS: Thumb sucking, etc? ___________ Nail biting? _______________
Mouth breathing? _____________ Lip or tongue biting? ________
VOICE: Speech: ____________ Stammer: _____________ Lisp: ______________

PRESENT HEALTH: Excellent:_____ Good: _____ Fair: _____ Poor: _____
Patient's dentist: ___________________ Patient's physician: ______________________
Brother(s) & Sister(s), names & ages: ____
Any orthodontic problems?____________________ Treated? ________________
Does **Father** have orthodontic problems? _____________ Treated? ________________
Does **Mother** have orthodontic problems?____________ Treated? ________________
Responsible Party's Email address____

Health History Update:

Date: _______________	Date: _______________	Date: _____________
Initials: _____________	Initials: _____________	Initials: ___________
Changes: ____________	Changes: ____________	Changes: ________