Risinger Orthodontics

Date _____

Patient Information:

First Name _____ General Dentist _____

Last Name _____ Referral Source: Dentist Family Member Other

Middle Name _____ Names of Family Members Seen in our office

Common Name _____ _____

Birthday _____/ _____/ _____ Age _____ If a minor, does patient live with: (please circle)

Address _____ mother father both guardian

City_____ Zip Code _____

Email _____

Best phone number to confirm appointments (via text message) (_____) _____ - _____

Responsible Party Information:

Please circle relationship:

Father Mother Grandparent Guardian Self

First Name _____ Birthday _____/ _____/ _____

Last Name _____ SS # _____/ _____/ _____

Common Name _____ Home Ph (____) _____- _____

Occupation _____ Work Ph (____) _____- _____

Cell Ph (____) _____- _____

Dental Insurance: Yes No

Insurance Name _____

Please circle insured relationship to patient:

Father Mother Spouse Grandparent Guardian Self

First Name _____ Birthday _____/ _____/ _____

Last Name _____ SS # _____/ _____/ _____

Middle Name _____ Home Ph (_____) _____- _____

Employer _____ Work Ph (_____) _____- _____

Occupation _____ Cell Ph (_____) _____- _____

Consent for Orthodontic Evaluation/Treatment

_____ _____

Patient/Parent Signature Date

715 Hill Country Dr. #3 Kerrville, TX 78028 (830)257-8922

Risinger Orthodontics

Dental Information:

Y / N

__/__Has patient seen general dentist in the last year?
__/__Any pain, clicking or discomfort in or near the ears?
__/__Injury to face, mouth, or teeth due to accident?
__/__Missing or extra permanent teeth?
__/__Any “gum” problems?
__/__Have patient’s tonsils or adenoids been removed?
__/__Teeth grinding

Y / N

__/__Cheek/tongue or lip chewing
__/__Thumb sucking
__/__Mouthing breathing
__/__Finger nail biting
__/__Clenching teeth
__/__Tongue thrusting
__/__Speech problems

In your own words, please explain the orthodontic problem:

_____

Medical Information:

Y / N

__/__History of fainting or dizziness
__/__Frequent or severe headaches
__/__Any heart disease
__/__Any sinus or respiratory disease
__/__Any blood disease
__/__Any liver disease
__/__Any thyroid disease
__/__Any kidney disease
__/__HIV positive
__/__Any venereal disease
__/__Any intestinal disease
__/__Any bone disease
__/__Any nervous/emotional problems
__/__Any high or low blood pressure
__/__Any endocrine problems
__/__Any problems with wound healing
__/__Any tumors or cancer
__/__Tonsillitis/frequent sore throats
__/__Any joint problems
__/__Rheumatic/Yellow /Scarlet fever
__/__Acquired Immune Deficiency Syndrome
__/__Is patient under medical care?
__/__Blood transfusions
__/__Is patient taking any medications

Y / N

__/__Does patient have a drug addiction?
__/__Is patient pregnant at this time?
__/__Measles/Mumps/Chicken Pox
__/__Has the patient ever had fever blisters?
__/__Rheumatism or Arthritis
__/__Has the patient reached puberty?
__/__Heart Murmur
__/__Mononucleosis
__/__Hepatitis
__/__Polio
__/__Diabetes
__/__Anemia
__/__Hemophilia
__/__Emphysema
__/__Epilepsy
__/__Asthma or Hay Fever
__/__Tuberculosis
__/__Any broken bones
__/__Prolonged bleeding
__/__Yellow Jaundice
__/__Radiation Therapy
__/__Chemical Therapy

__/__Latex allergy

Any known drug allergies _____

Medications patient is currently taking _____

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