PATIENT HISTORY FORM

PATIENT INFORMATION

Patient Name_____Date of Birth_____ Sex: M F Marital Status: M D S W

Home Phone No.:_____ Work Phone:_____Cell Phone:_____

Social Security No.:_____Driver's License No.:_____Spouse'sName:_____

StreetAddress_____City:_____State:_____ZipCode:_____

Dentist:_____ Patient's Physician:_____

E-Mail:_____Hobbies:_____

IF PATIENT IS A MINOR

Mother's Name:_____ Social Security No.:_____ E-Mail:_____

Address (if different from patient):_____ City:_____State:_____ Zip Code:_____

Mother's Employer:_____ Business Phone:_____ Home Phone:_____

Father's Name:_____ Social Security No.:_____ E-Mail:_____

Address (if different from patient)_____ City:_____State:_____ Zip Code:_____

Father's Employer:_____ Business Phone:_____ Home Phone:_____

RESPONSIBLE PARTY INFORMATION (If Other Than Patient)

Name:_____ Social Security No.:_____ Driver's License No.:_____

Date of Birth:_____ Relationship to Patient:_____ Home Phone No.:_____ Cell Phone:_____

Street Address (No P.O. Box unless mail delivery only at P.O. Box):_____

City:_____ State:_____ Zip Code:_____ How Long at This Address: _____Years _____Months

EMPLOYER INFORMATION (Responsible Party)

Employer:_____ Occupation:_____ Business Phone:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Years at Employer:_____Years_____Months

Spouse's Employer:_____ Occupation:_____ Business Phone:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Years at Employer:_____Years_____Months

INSURANCE INFORMATION

Insured's Name:_____ID Number:_____ Date of Birth:_____

Insurance Company:_____ Group No:_____

Insurance Phone Number:_____ Insured's Employer:_____

Employer Address:_____City:_____St.:_____Zip:_____

EMERGENCY INFORMATION

Person to Contact:_____ Relationship to Patient:_____ Phone No.:_____

Address:_____ City:_____ State:_____ Zip Code:_____

(COMPLETE OTHER SIDE)

PATIENT'S MEDICAL HISTORY

Have you been under the care of a physician in the last two years:_____ Have you ever had or do you now have any of the following:

___Prolonged Bleeding
___Epilepsy
___Diabetes
___Heart Problems
___Rheumatic Fever
___Bone Disorders
___Tuberculosis
___Hepatitis (any form)
___AIDS or HIV

___ Cancer
___Anemia
___Asthma
___Fainting or Dizziness
___Nervous Disorder
___Endocrine Problems
___Liver Problems
___Birth Defects
___Allergies

Have you had any operations: YES NO

Have you been hospitalized: YES NO

List any medications you are on:
_____
_____
_____

Are you allergic to any medications: YES NO Please List:_____

PATIENT'S DENTAL HISTORY

Do you have any of the following:

_____Any family members who have had orthodontics.
_____Teeth sensitive to hot/cold.
_____Injuries to face, jaw, mouth or teeth.
_____Bleeding gums, bad taste in mouth.
_____Root canals, crowns, or bridges.
_____Suck your thumb and/or fingers.
_____Any clicking, popping or pain of the jaw, joints (TMJ).
_____Any missing teeth or extra teeth.
_____Trouble chewing.

Date of most recent dental exam:_____
How often do you brush your teeth:_____
How often do you floss your teeth:_____

Your signature below gives Dr. Bryan E. Taylor permission to treat the above named patient at the initial examination. If comprehensive treatment is begun, you will sign and be given a detailed informed consent.

_____SIGNATURE **(if patient is a minor, PARENT/GUARDIAN must sign)**

_____SIGNATURE OF ORTHODONTIST

_____TODAY'S DATE

Updates: (Date and Initial)_____

By signing below, I authorize BRAZOSBRACES ORTHODONTICS to obtain a consumer credit report about me as part of the consideration for financing for services provided by BRAZOSBRACES ORTHODONTICS. I understand that a copy of my credit report will be obtained by BRAZOSBRACES ORTHODONTICS and that the contents of my credit report will be considered for financing purposes only and will be kept confidential.

_____ _____

Signature **Date**