ORTHODONTICS
For Children & Adults

John A. Freeman D.D.S., M.S.D.

Welcome to our practice . . . please tell us about yourself!

Today's Date:_____

PATIENT'S NAME (LAST, FIRST, INITIAL)	PREFERRED FIRST NAME	BIRTHDATE	SEX ☐ MALE ☐ FEMALE
STREET ADDRESS	CITY	ZIP	HOME PHONE NO.
IN CASE OF EMERGENCY, NOTIFY (NAME)	PHONE	RELATIONSHIP TO PATIENT	HOBBIES & SPORTS (optional)
WHO MAY WE THANK FOR REFRRING YOU? ☐ DENTIST ☐ FAMILY MEMBER ☐ FRIEND ☐ SIGN ☐ YELLOW PAGES ☐ OTHER (DESCRIBE):			
DENTIST'S NAME	WHEN LAST VISITED (approximate)	PHYSICIAN'S NAME	WHEN LAST VISITED (approximate)
FREQUENCY OF DENTAL CHECKUPS ☐ TWICE A YEAR ☐ ONCE A YEAR ☐ ONLY IF THERE'S A PROBLEM ☐ NEVER			FREQUENCY OF FLOSSING EACH WEEK?

Office Notes:

- PLEASE COMPLETE THE SECTION BELOW.
- THE SECTION AT THE RIGHT IS FOR A SPOUSE OR OTHER PERSON WHO IS FINANCIALLY RESPONSIBLE FOR THE PATIENT'S ACCOUNT

WORK INFORMATION

May we call you at work? ☐ Yes ☐ No	WORK PHONE NO. EXTENSION
OCCUPATION	EMPLOYER
WORK ADDRESS	
CITY STATE ZIP	
HOW LONG HAVE YOU WORKED THERE?	

DENTAL INSURANCE INFORMATION

ORTHODONTIC INSURANCE? ☐ Yes ☐ No ☐ ???	SOCIAL SECURITY NO.
INSURANCE CO. NAME	GROUP NO. (IF KNOWN)
INSURANCE CO. STREET ADDRESS	
CITY STATE ZIP	
INSURANCE CO. PHONE NO.	

May we bill insurance for you? ☐ Yes ☐ No
*Signature:*_____

For Office Use Only	
ORTHO INS? ☐ YES ☐ NO	RECORDS SEP? ☐ YES ☐ NO
ORTHO MAX:	% PAID:
DEDUCTABLE:	BILL @:
NOTES:	

SPOUSE OR OTHER SECOND RESPONSIBLE PARTY

NAME (LAST, FIRST, INITIAL)	
STREET ADDRESS (IF DIFFERENT FROM PATIENT'S)	
CITY STATE ZIP	
HOME PHONE NO. (IF DIFFERENT)	WORK PHONE NO.
OCCUPATION	EMPLOYER
WORK ADDRESS	
CITY STATE ZIP	
RELATIONSHIP TO PATIENT (SPOUSE, PARENT, ETC.)	

DENTAL INSURANCE INFORMATION

BIRTHDATE OF RESPONSIBLE PARTY	SOCIAL SECURITY NO.
INSURANCE CO. NAME	GROUP NO. (IF KNOWN)
INSURANCE CO. STREET ADDRESS	
CITY STATE ZIP	
INSURANCE CO. PHONE NO.	

May we bill insurance for you? ☐ Yes ☐ No
*Signature:*_____

For Office Use Only	
ORTHO INS? ☐ YES ☐ NO	RECORDS SEP? ☐ YES ☐ NO
ORTHO MAX:	% PAID:
DEDUCTABLE:	BILL @:
NOTES:	

Health & Dental History

1. Do you have a health problem? ☐
   Yes ☐ No
2. Are you under treatment by a physician? ☐
   Yes ☐ No
3. Are you currently taking any medicine? ☐
   Yes ☐ No
4. Are you sensitive or allergic to anything or ever had an unfavorable reaction ☐
   Yes ☐ No
   to any medicine?
5. Have you ever been hospitalized? ☐
   Yes ☐ No
6. Have you had any previous orthodontic treatment? ☐
   Yes ☐ No
7. Have other members of your family—parents, brothers, sisters, children— ☐
   Yes ☐ No
   had orthodontic treatment?
8. Do you have difficulty chewing or swallowing? ☐
   Yes ☐ No
9. Do you experience noise, pain, or difficulty with movement in your jaws? ☐
   Yes ☐ No

10. Are you planning to move from San Luis Obispo County within the next 3 years? ☐
    Yes ☐ No
11. Have you had any of the following? (Check all that apply)

☐ Heart trouble or congenital heart lesions	☐ Thyroid abnormalities
☐ Replacement heart valve or replacement joint	☐ Hepatitis or other liver disorders
☐ Rheumatic Fever	☐ Kidney disorders
☐ Asthma or other lung disorders	☐ Blood or bleeding disorders
☐ Tuberculosis	☐ Anemia
☐ Skin rash or hives	☐ Epilepsy
☐ Diabetes	☐ Nervousness
☐ Stomach disorders	☐ Fainting or dizziness
☐ Hormone disorders	☐ Other _____

DATE	History Updates