scenic city
orthodontics
TYLER PRENTICE DMD MS

PATIENT INFORMATION (please know that we respect and protect your privacy)

Date ______ Age ______ Birth Date ______ Sex ______

Patient's Name
Last ______ First ______ MI ______ Preferred Name ______

Home Address
Street ______ City ______ State ______ ZIP ______ Home Phone ______

Driver's License # (if applicable) ______ Social Security # ______

Whom may we thank for recommending our services? ______

Names and ages of children in family ______ ______
______ ______

Have any been seen in our office? ☐ No ☐ Yes: ______

RESPONSIBLE PARTY INFORMATION

(If patient is an adult, please provide additional info. If patient is a minor, provide parent or legal guardian information.)

Last ______ First ______ MI ______ Preferred Name ______

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Driver's License # ______

Mailing Address ______

How long at this address? ______ years Previous Address (if less than 3 years) ______

Home Phone ______ Cell Phone ______ Work Phone ______ Preferred number ______

Email addresses for appointment reminders, etc. ______

Social Security # ______ Birth Date ______ Relationship to patient ______

Employer ______ Occupation ______ Number of years employed ______

Spouse's Name ______ Relationship to patient ______

Social Security # ______ Birth Date ______ Phone ______

Employer ______ Occupation ______ Number of years employed ______

EMERGENCY CONTACT INFORMATION

Name ______

Phone Number(s) ______ Relationship to patient ______

PRIMARY DENTAL INSURANCE *(if applicable)*

Insured's Full Name ______ Birth Date ______

Social Security # ______ Relationship to patient ______

Insurance Company ______ Group # ______ Contract # ______

Insurance Company Address ______

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't Know Insurance Phone # ______

Insured's Employer ______

SECONDARY DENTAL INSURANCE *(if applicable)*

Insured's Full Name ______ Birth Date ______

Social Security # ______ Relationship to patient ______

Insurance Company ______ Group # ______ Contract # ______

Insurance Company Address ______

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't Know Insurance Phone # ______

Insured's Employer ______

GENERAL INFORMATION

What concerns the patient about his/her teeth and jaws? ______

Other family members with similar condition? ______

Who suggested that the patient might need orthodontic treatment? ______

Has the patient ever had any previous orthodontic treatment or consultation? ______

Why did you select our office? ______

What school does the patient attend? ______ Grade? ______

List interests and hobbies. ______

DENTAL HISTORY

Patient's dentist ______ Date of last exam? ______

Remaining recommended dental work? ______

How often does the patient have dental check-ups? ______

Have there been any injuries to the face, mouth or teeth? ______

Has the patient been informed of any missing or extra permanent teeth? ______

Please check any of the following conditions that apply to patient:

- ☐ Bad Breath
- ☐ Bleeding
- ☐ Bridgework
- ☐ Broken Fillings
- ☐ Clicking/Popping Jaws
- ☐ Crowns
- ☐ Earaches
- ☐ False Teeth
- ☐ Food Between Teeth
- ☐ Grinding Teeth
- ☐ Jaw Pain
- ☐ Loose Teeth
- ☐ Mouth Breather
- ☐ Neck Pain
- ☐ Partial Dentures
- ☐ Sensitivity to Cold
- ☐ Sensitivity to Hot
- ☐ Sensitivity to Sweets
- ☐ Sensitivity when Biting
- ☐ Sores/Growth in Mouth

MEDICAL HISTORY

Name of Physician ______ Date of last visit ______

Please list all medications patient is currently taking ______

Allergies (drug/latex/nickel/etc.) ______

(Women) Is patient pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control? ☐ Yes ☐ No

Does patient have a history of any of the following (past or present)?

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back problems
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cough, Persistent
- ☐ Cough Up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Major Surgery
- ☐ Mitral valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

Other ______

Describe heart problems ______ Does patient require premedication? ☐ Yes ☐ No

To the best of my knowledge, the provided information is complete and correct. I give permission for any photographs, x-rays, or study models to be used for displays at scientific presentations and/or publications of a scientific nature or for group purposes to further the art and science of orthodontics. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

______
Signature of Patient or Parent/Guardian if Patient is a Minor

______
Date

______
Printed Name of Patient or Parent/Guardian if Patient is a Minor