Granger Orthodontics

Date _____

Name patient prefers to be called _____

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

Has someone you know been treated by us? Name/relation? _____

Patient Information

Name _____ Birth Date _____
Last First Middle

Age (yrs/mo's) _____ Sex : M F Email _____

Address _____ City _____ ZIP _____

Phone: Home _____ Cell _____ Work _____

Interests, talents, sports or hobbies? _____

Guardian's Names _____ Emergency Phone #_____
Mother Father

Person Financially Responsible

Name _____ Email _____
Last First Middle

Address _____ City _____ ZIP _____

Birth date _____ SSN _____ Relation to Patient _____

Phone: Home _____ Work _____ Cell _____

Occupation _____ Employer _____ Yrs at company _____

Dental Insurance Information

Primary Ins. Co. _____ Group # _____ Subscriber # _____

Insured's Name _____ Insured's SSN _____
Last First Middle

Secondary Ins. Co. _____ _____ Group # _____ Subscriber # _____

Insured's Name _____ Insured's SSN _____

Dental and Medical History

Please describe the orthodontic problem or what about your mouth or smile you want changed:

_____

Family Dentist _____ City _____ Date of last visit _____

Please circle if you have or had any of the following:

Allergies (please list below)	Hepatitis	Tuberculosis	High Blood Pressure / Heart Prob
HIV/AIDS	Headaches	Seizures	Asthma / Difficulty Breathing
Trauma to teeth or face	Bleeding problems	Hospitalization (non maternity)	
Thumb-sucking habit	Missing or extra teeth	Noise or pain in jaw joint	

List other medical conditions _____

Current medications _____

Allergies _____

I certify the information above is accurate to the best of my knowledge. I understand the information will be used by the orthodontist to help determine appropriate treatment. I will notify the orthodontist of any change in my medical or dental status. I understand that treatment plans involving extended credit may require a credit check on my credit rating.

Signature _____ ***Date*** _____