Raymond Barbre, DDS, MS, PC

Pt. # ______________________ Date ______________________

PATIENT INFORMATION

LAST NAME	FIRST	NICKNAME	BIRTHDATE	AGE
ADDRESS	CITY	ZIP	PHONE	
PLEASE LIST NAMES AND AGES OF BROTHERS AND SISTERS				
HAS ANY MEMBER OF FAMILY UNDERGONE ORTHODONTIC TREATMENT?				
PATIENT'S DENTIST	DATE LAST VISIT	WHOM MAY WE THANK FOR REFERRING YOU?		

RESPONSIBLE PARTY INFORMATION

NAME ____
LAST FIRST MIDDLE

ADDRESS ____
STREET CITY STATE ZIP

NO. YEARS AT THIS ADDRESS __________ HOME PHONE ____________________ WORK PHONE ____________________

PREVIOUS ADDRESS (IF LESS THAN 3 YEARS) ____
STREET

____
CITY STATE ZIP

SOCIAL SECURITY # ____________________ BIRTHDATE ______________ RELATIONSHIP TO PATIENT ______________

EMPLOYER ______________________________ OCCUPATION ____________________ NO. OF YEARS EMPLOYED ______

SPOUSE'S NAME ____
LAST FIRST MIDDLE

SPOUSE'S EMPLOYER ____

OCCUPATION ______________________________ WORK PHONE ____________________

NEAREST RELATIVE NOT LIVING WITH YOU ADDRESS PHONE

INSURANCE - PRIMARY

TYPE COVERAGE

☐ MEDICAL ☐ DENTAL ☐ ORTHODONTIC

INS. CO. NAME ______________________________

INS. CO. PHONE # ______________________________

GROUP NUMBER ______________________________

POLICY HOLDER NAME ______________________________

POLICY HOLDER SOC. SEC. # ______________________________

INSURANCE - SECONDARY

TYPE COVERAGE

☐ MEDICAL ☐ DENTAL ☐ ORTHODONTIC

INS. CO. NAME ______________________________

INS. CO. PHONE # ______________________________

GROUP NUMBER ______________________________

POLICY HOLDER NAME ______________________________

POLICY HOLDER SOC. SEC. # ______________________________

MEDICAL HISTORY

Please check box if patient has or has had:

- ☐ Joint swelling
- ☐ Bone disorders
- ☐ Heart trouble
- ☐ Rheumatic fever
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Emotional problems
- ☐ Kidney involvement
- ☐ Immune Systems Disorders: HIV, ARC or AIDS
- ☐ Asthma
- ☐ Epilepsy
- ☐ Prolonged bleeding
- ☐ Faintness/Dizziness
- ☐ Tonsils removed
- ☐ Adenoids removed
- ☐ Endocrine problems

List any other serious illnesses:

List any allergies:

Is patient under physician's care presently? Reason:

DENTAL HISTORY

Please check box if answer is YES

- ☐ Any injuries to face, mouth, teeth? (circle)
- ☐ Thumb, finger, lip sucking? (circle)
- ☐ Mouth-breathing while asleep, awake? (circle)
- ☐ Any missing permanent teeth?
- ☐ Any extra permanent teeth?
- ☐ Any teeth removed by extraction?
- ☐ Is there a tongue thrust problem?
- ☐ Any speech problems?
- ☐ Any pain or clicking on opening mouth?
- ☐ Does patient visit dentist regularly?
  Date of last dental visit ______________
- ☐ Has an orthodontist been consulted previously? Reason:

What would you like to have orthodontic treatment accomplish?

UPDATES (DATE & INIT.) _________ _________ _________ _________ _________ ______________________

SIGNATURE