



Date: _____

About You

Patient Name: _____
 LAST FIRST M.I.

Birthday: _____ Age: _____ Marital Status: _____

SS# _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

How long at current address? _____

Dentist Name: _____

Physician Name: _____

Employer: _____

Position: _____

Address: _____

City: _____ State: _____ Zip: _____

How long at current employer? _____

If less than 6 months list previous employer: _____

May we contact you by e-mail? Yes _____ No _____

E-mail address: _____

The greatest compliment we can receive is the referral of friends and family. Whom may we thank for referring you? _____

Address (if known) _____

Significant Other/Spouse

Significant Other: _____
 LAST FIRST M.I.

Birthday: _____ Marital Status: _____

SS#: _____

Cell Phone: _____ Work Phone: _____

Employer: _____

Position: _____

How long at current employer? _____

If less than 6 months list previous employer: _____

May we contact them by e-mail? Yes _____ No _____

E-mail address: _____

Children

Name	Age	Birth date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Emergency Contact

In case of emergency, please contact:

Name of nearest relative or family friend not living with you

PERMANENT FAMILY CONTACT

Name: _____

CONTACT ADDRESS AND PHONE NUMBER

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Relationship to Patient: _____

Insurance Information

Primary Dental Insurance

Insurance Co Name: _____
 Address: _____
 City: _____ State _____ Zip: _____
 Insurance Co Phone: _____
 Insured's Name: _____ Insured's DOB: _____
 Insured ID # _____ Insured Group # _____
 Insured SS # _____ Relationship to Patient _____
 Insured Employer: _____ Employer Phone # _____

*** Please bring in a copy of your insurance card to be scanned**

Secondary Dental Insurance

Insurance Co Name: _____
 Address: _____
 City: _____ State _____ Zip: _____
 Insurance Co Phone: _____
 Insured's Name: _____ Insured's DOB: _____
 Insured ID # _____ Insured Group # _____
 Insured SS # _____ Relationship to Patient _____
 Insured Employer: _____ Employer Phone # _____

*** Please bring in a copy of your insurance card to be scanned**

Medical Information

<p>Y N Are you in good health? Y N Heart Problems? Y N Rheumatic Fever Y N Heart Murmur Y N Shortness of Breath Y N Liver Problem? Y N Do you have hepatitis? Y N Nerve/Neurological Problems? Y N History of Fainting or Dizziness? Y N Lung/Breathing Problems? Y N Asthma Y N Blood/Bleeding Problems? Y N History of Tobacco Use? If so, what kind? _____</p>	<p>Y N Problems with Healing? Y N Psychological/Emotional Problems? Y N High/Low Blood Pressure? Y N Cancer or History of Cancer? Y N HIV/Aids? Y N Rheumatism or Arthritis? Y N History of Drug Use? Y N Tuberculosis? Y N Hormone/Endocrine Problems? Y N Do you get frequent cold sores? Y N Do you have artificial joint/implants? Y N Thyroid Problems? Y N Kidney Problems?</p>	<p>Last physical examination was on: _____ Please list all medications: _____ _____ Y N Are you currently under medical care? Y N Are you aware of any disease, condition or problem not listed that we should know about? If yes, what? _____ Y N Are you allergic to any medications? Please list: _____ Y N Do you have asthma or seasonal/environmental allergies?</p>
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Dental Information

<p>Y N Have you seen a general dentist in the last year? Y N Any pain, clicking or discomfort in or near the ear (TMJ)? Y N Has your mouth, face or teeth been injured by a fall or accident? Y N Have you been informed of missing or extra permanent teeth? Y N Are you aware of any "gum" or periodontal problems? Y N Has a physician or dentist advised antibiotics before a dental exam? Do you have or ever had any of the following habits? Y N Cheek, tongue or lip biting Y N Thumb or finger sucking Y N Mouth breathing Y N Speech problems</p>	<p>Y N Clenching teeth Y N Tongue thrusting Y N Grind teeth Y N Have you ever worn a helmet for head molding? Y N Have you been examined by an orthodontist before? If yes, by whom? _____ Y N Have you had a recommendation that you need orthodontic treatment? Y N Have other members of your family had orthodontic treatment? If yes, who were they? _____</p>
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AUTHORIZATION

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and that it is my responsibility to inform this office of any changes to this information promptly. I authorize release of any information to insurance carriers and to other health care providers involved in coordination of care. I authorize Dr. John Warford and the staff of Warford Orthodontics to perform any necessary dental services that are needed during diagnosis and treatment. I understand that where appropriate, credit bureau reports may be obtained.

I understand by bringing in my child/step-child for the initial visit, I am responsible for payment independent of what a divorce decree may state. Payment/Reimbursement must be made between the divorced parents. The Aligner Studio will not intervene.

SIGNATURE (IF MINOR, PARENT'S SIGNATURE) _____

For Office Use Only: Updates: (Date and Initial) _____