Patient Biographical Information			
First Name:	Middle Initial:	Last Name:	
Nickname:	Birthdate:	Gender:	
Address:	City:	State:	Zip:
Main Phone:	2nd/Cell Phone:	Email:	
Occupation or School Level:	Please list the names of any family in the practice:		
List any sports. Hobbies or musical instruments played and other interests:			
Whom may we thank for referring you to our practice?			

Emergency Contact	
Person to be contacted in case of emergency:	Relationship:
Phone Number(s):	

Responsible Party Information			
Responsible Party 1			
First Name:	Middle Initial:	Last Name:	
Relationship to Patient:	Email:		
Address:	City:	State:	Zip:
Main Phone:	2nd/Cell Phone:	Employer:	
Occupation:	Work Phone #:		
Responsible Party 2			
First Name:	Middle Initial:	Last Name:	
Relationship to Patient:	Email:		
Address:	City:	State:	Zip:
Main Phone:	2nd/Cell Phone:	Employer:	
Occupation:	Work Phone #:		

Dental Insurance Information			
Policy Holder's Name:	Relationship to Patient:	Subscriber Date of Birth:	
Policy Holder's Employer:	Insurance Company:	Subscriber ID #:	Group No.:
Insurance Co. Address:	City:	State:	Zip:
Insurance Co. Phone No.:	Do you have dual dental coverage?		
Policy Holder's Name:	Relationship to Patient:	Subscriber Date of Birth:	
Policy Holder's Employer:	Insurance Company:	Subscriber ID #:	Group No.:
Insurance Co. Address:	City:	State:	Zip:
Insurance Co. Phone No.:			

Medical History					
Physician Name:		Office Phone:		Date of Last Exam:	
Are you currently under medical treatment?					
If so, please explain for what:					
List any medications currently being taken by the patient (include non-prescription):					
Taken/Taking Bisphosphonates?		If yes, for what condition?		FEMALES: Are you or could you be pregnant?	
Allergies or drug reaction to:					
Latex		Penicillin or other antibiotics		Sulfa drugs	

Aspirin, Ibuprofen, Tylenol		Local anesthetics		Codeine or other narcotics	
Other:					
List any drug allergies or sensitivities (not listed above) that the patient may have:					
Please select YES if the patient has had any of the conditions listed below either now or in the past. Cannot be blank.					
Hypertension/High Blood Pressure		Rheumatic Fever		Heart Murmur	
Mitral Valve Prolapse		Heart Conditions		Epilepsy/Convul-sions	
Fainting/Seizures		Hay Fever/Allergies		ADHD	
Tuberculosis		Thyroid Problems		Kidney Disease	
Respiratory Problems		Diabetes		Asthma	
X-ray/Radiation (Cancer) Therapy		HIV/AIDS		Hepatitis/Jaundice	
Any developmental/genetic issues that would effect how we communicate with your child?					
If any of the above medical questions were answered 'Yes' , please explain:					

Dental History			
Dentist Name:		Address:	
Phone:		Last Dental Visit:	
Do you authorize release of information about orthodontic treatment to the patient's dentist?			
Please select YES if the patient has had any of the conditions listed below either now or in the past. Cannot be blank.			
Bleeding gums?		Frequent headaches?	
Teeth sensitive to hot or cold food/liquids?		Teeth sensitive to sweet or sour food/liquids?	
Clench or Grind Teeth?		Bite Lips or Cheeks?	
Had Blows to Teeth?		Pain in Any Teeth?	
Any Difficult Extractions?		Frequent Sores In/Around Mouth?	
Prolonged Bleeding After Extractions?		Head, Neck or Jaw Injuries?	
Clicking in the Jaw?		Pain in the Jaw?	
Difficulty Opening or Closing Jaw?		Difficulty in Chewing?	
Have or Had Thumb/Finger Habit?		Had Prior Orthodontic Consultation or Treatment?	
Please explain the nature of the orthodontic problem in your own terms:			

I certify that the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Dr. Simi to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child for orthodontic care to the patient's general dentist, third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to Dr. Simi, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Completed By: Date:

Date Reviewed:	Date Reviewed:	Date Reviewed: