Date______________

Confidential Responsible Party Information

A B C

Name____ Marital Status_________
Last First Middle

Residence____ ☐ Own ☐ Rent
Street City State Zip

Mailing Address____
Street City State Zip

How long at this address_______ **Phone:** Home_________________Cell________________ Work_______________

Previous Address (if less than 3 yrs.)____
Street City State Zip

Social Security #___________________ Birthdate___________________ Relationship to Patient_______________

Employer_________________________ Occupation_________________ No. Years Employed________________

Spouse's Name____ Relationship to Patient_______________
Last First Middle

Employer_________________________ Occupation_________________ No. Years Employed________________

Social Security #___________________ Birthdate___________________ Cell Phone _______________________

Confidential Patient Information

Patient's Name____
Last First Middle

Address____
Street City State Zip

Cell Phone________________________ Birthdate___________________Age ______ SS#___________________

If patient is a minor, give parent's or guardian's name____

List other family members treated by Dr. Bryan____

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

Insurance Information

Policy Holder's Name_____________________________Birthdate__________ Soc.Sec. #___________________

Insurance Company______________________________ Group #________________ Policy/ID # _______________

Insurance Co. Address____ Insurance Co. Phone_______________

Policy Holder's Employer____

Do you have dual coverage? No ☐ Yes ☐ If yes:

Policy Holder's Name____ and Soc. Sec. #___________________

Insurance Company______________________________ Group No.____________ Policy/ID# _________________

Insurance Co. Address____ Insurance Co. Phone_______________

Policy Holder's Employer____

Emergency Information

Name of nearest relative not living with you____

Complete Address____

Phone____________________________ Relationship:_______________________________

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor)____

Updates (date & initial)____

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Medical History

Do you currently have a personal physician? **Y N**

Physician's Name: ____

Ph # (_______) ________________Date of last visit: ______________________

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? **Y N**

Please explain:____

Women: Are you using a prescribed method of birth control? **Y N**

Are you Pregnant? **Y N** Week #: _______ Are you nursing? **Y N**

Have you ever had any of the following diseases of medical problems?

Y N Abnormal Bleeding	**Y N** Heart Surgery/Pacemaker
Y N Anemia	**Y N** Hemophilia
Y N Artificial Bones/Joints/Valves	**Y N** Hepatitis
Y N Arthritis	**Y N** High/Low Blood Pressure
Y N Asthma	**Y N** HIV+/Aids
Y N Blood Transfusion	**Y N** Hospitalized for any Reason
Y N Cancer/Chemotherapy	**Y N** Kidney Problems
Y N Congenital Heart Defect	**Y N** Mitral Valve Prolapse
Y N Diabetes	**Y N** Psychiatric Problems
Y N Difficulty Breathing	**Y N** Radiation Treatment
Y N Drug/Alcohol Abuse	**Y N** Rheumatic/Scarlet Fever
Y N Emphysema	**Y N** Shingles
Y N Epilepsy/Seizures/Fainting	**Y N** Sickle Cell Disease/Traits
Y N Fever Blisters/Herpes	**Y N** Sinus Problems
Y N Frequent/Severe Headaches	**Y N** Stroke
Y N Glaucoma	**Y N** Tuberculosis (TB)
Y N Heart Attack	**Y N** Ulcers/Colitis
Y N Heart Murmur	**Y N** Venereal Disease

Are you allergic to any of the following?

Y N Aspirin **Y N** Dental Anesthetics **Y N** Penicillin

Allergies continued

Y N Codeine **Y N** Erythromycin **Y N** Tetracycline

Y N Metal/Plastic **Y N** Latex **Y N** Other

Please list any other drug/material allergies: ______________________

___________________________ ____________________________

General Dentist______________________ Last visit __________

Dental History

What would you like orthodontics to accomplish?

____

Have you ever been evaluated for orthodontic treatment? **Y N**

Have you ever had a serious/difficult problem associated with any previous dental work? **Y N**

Do you now or have you ever experienced Pain/discomfort in your jaw joint (TMJ/TMD) **Y N**

Your current dental health is: Good Fair Poor

Do you like your smile? Y N Do your gums bleed? **Y N**

Have you ever had an injury to your: Mouth Teeth Chin

Indicate any speech problems _________________________________

Do you breathe through your mouth? While Awake While Asleep

Do you have any missing or extra permanent teeth? **Y N**

Have you ever taken Fosamax or any other bisphosphonate? **Y N**

Have you ever taken Phen-Fen? **Y N**

Do you Smoke or use tobacco in any form? **Y N**

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles and unpaid balances that my insurance does not pay. I hereby authorize payment of the insurance benefits directly to this office.

____

SIGNATURE OF PARENT OR GUARDIAN DATE

Office Use Only

I verbally reviewed the medical/Dental information above with the patient named herein.

Doctor's comments:____

____

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