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)_____

What would you like orthodontics to accomplish?

_____

Has your child ever taken Phen-Fen? (Redux or Pondimin) If yes, when? _____ **Y N**

Has your child ever been evaluated or had orthodontic treatment before? **Y N**

Have there been any injuries to the face, mouth, teeth or chin? **Y N**

List musical instruments played: _____

Have adenoids of tonsils been removed? **Y N**

Has your child been informed of any missing or extra permanent teeth? **Y N**

Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? **Y N**

Does your child brush his/her teeth daily? **Y N**

Does your child floss his/her teeth daily? **Y N**

Child's Physician: _____

Phone # (___)_____Date of last visit: _____

Is your child under the care of a physician? **Y N**

Has puberty begun? **Y N**

Girls – Has menstruation begun? **Y N**

Please describe your child's current physical health:

Good Fair Poor

Please list all drugs that your child is currently taking:

_____

Please list all drugs/things that your child is allergic to:

Latex **Y N** Metals/Nickel **Y N** Plastics **Y N**

_____

_____

Has your child ever had any of the following Medical problems?

Y N	Abnormal Bleeding	**Y N**	Diabetes
Y N	ADD/ADHD	**Y N**	Handicaps/Disabilities
Y N	Allergies to Any Drugs	**Y N**	Hearing Impairment
Y N	Any Hospital Stays	**Y N**	Heart Murmur
Y N	Any Operations	**Y N**	Hemophilia
Y N	Artificial Bones/Joints	**Y N**	Hepatitis
Y N	Artificial Valves	**Y N**	HIV+/AIDS
Y N	Asthma	**Y N**	Kidney/Liver Problems
Y N	Cancer	**Y N**	Lupus
Y N	Convulsions/Epilepsy	**Y N**	Rheumatic/Scarlet Fever
Y N	Congenital Heart Defect	**Y N**	Tuberculosis

Please discuss any medical problems that your child has had:

_____

_____

General Dentist_____Last visit _____

Has your child ever experienced any of the following?

Y N	Clenching/Grinding Teeth	**Y N**	Nursing/Bottle Habits
Y N	Lip Sucking/Biting	**Y N**	Speech Problems
Y N	Mouth Breather	**Y N**	Thumb/Finger Sucking
Y N	Nail Biting	**Y N**	Tongue Thrust

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 GUARDIAN DATE

Office Use Only

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

Doctor's comments:_____

_____

_____