PARK CITY ORTHODONTICS
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WELCOME TO PARK CITY ORTHODONTICS

We are excited to see you for your first visit to our office. We promise to make it an informative and enjoyable experience.

Please confirm the correctness of the completed information and fill in the empty fields as completely as possible.

Please Tell Us About Yourself:

Today's Date: _____

Name: _____

Nickname: _____

Birth Date: _____

Home #: _____

Cell #: _____

Home Address: _____

City _____ State_____ Zip_____

Email: _____

Work #:_____

Personal Information:

Whom may we thank for referring you?

Their name?:_____

General Dentist's Name:_____

Last Dental Visit (date):_____

Your Marital Status:_____

Emergency Contact:_____

Relationship to you?:_____

Emerg, Contact Phone#: _____

Your Hobbies/Interests:_____

Primary Orthodontic Insurance:

Insurance Co. Name_____

Address:_____

Phone: _____

Policy Owner's Name:_____

Relationship to patient: _____

Group # (plan or policy#: _____

Policy Owners Birthdate:_____

SS#: _____

Policy Owners Employer:_____

Secondary Orthodontic Insurance:

Insurance Co. Name_____

Address:_____

Phone: _____

Policy Owner's Name:_____

Relationship to patient: _____

Group # (plan or policy#: _____

Policy Owners Birthdate:_____

SS#: _____

Policy Owners Employer:_____

Medical History

What is your main orthodontic concern? _____

Have you ever been evaluated or had orthodontic treatment before? _____ yes _____ no

Have there been any injuries to the face, mouth, teeth or chin? _____ yes _____ no

Have your adenoids or tonsils been removed? _____ yes _____ no

Have you been informed of any missing or extra permanent teeth _____ yes _____ no

Do you brush your teeth daily? _____ yes _____ no

Do you floss your teeth daily? _____ yes _____ no

Are you under the care of a physician _____ yes _____ no

Please describe your current physical health: ____ Good ____ Fair ____ Poor

List any musical instruments played: _____

Please list all drugs that you are currently taking:_____

Please list all drugs to which you are allergic:_____

Have you ever had any of the following medical problems? (circle yes or no)

Y	N	Abnormal bleeding	Y	N	Diabetes
Y	N	Allergies to any drugs	Y	N	Handicaps / Disabilities
Y	N	Allergic to Latex / Metals	Y	N	Hearing Impairment
Y	N	Allergic to Plastic	Y	N	Heart Murmur
Y	N	Any Hospital Stays	Y	N	Hemophilia
Y	N	Any Operations	Y	N	Hepatitis
Y	N	Asthma	Y	N	HIV+ / AIDS
Y	N	Cancer	Y	N	Kidney / Liver Problems
Y	N	Congenital Heart Defect	Y	N	Rheumatic/Scarlet Fever
Y	N	Convulsions / Epilepsy	Y	N	Tuberculosis (TB)

Do you exhibit any of the following habits?

Y	N	Clenching/ Grinding Teeth	Y	N	Nursing Bottle Habits
Y	N	Lip Sucking / Biting	Y	N	Speech Problems
Y	N	Mouth Breathing	Y	N	Thumb / Finger Sucking
Y	N	Nail Biting	Y	N	Tongue Thrusting

If you answered yes to any of the above, please explain:_____

_____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

_____ _____

Signature Date