JOHN M. RICHARDS, D.D.S., M.S., P.A.

Orthodontist

--PATIENT INFORMATION--

Patient's Name_____**Age**_____**Sex**_____
(first) (initial) (last)
Social Security #_____**Date of Birth**_____**Nickname**_____
Occcupation_____**Marital Status**_____**Spouses Name**_____
Residence Address_____
(Street) (City/State) (Zip)
Mailing Address_____
(Street) (City/State) (Zip)
Home Phone_____**Mobile Phone**_____ **Bus. Phone**_____
(If Applicable) School_____**Grade**_____
Patient Email Address: (Not Parents)_____
Dentist_____**Physician**_____
Who may we thank for referring this patient?_____
(Name)
Nearest Relative not living with you (for emergency purposes)_____
_____**Phone number**_____
(City/State)

--FINANCIAL INFORMATION--

Person responsible for this account_____**Social Security #**_____
Residence Address_____**Home Phone**_____
(Street) (City/State) (Zip) **Mobile Phone**_____
Employer_____**Occupation**_____
Orthodontic Insurance? Yes/No Company's Name_____
(circle One)
Insured's Name_____**Insured's Date of Birth**_____

--ADDITIONAL INFORMATION FOR MINORS--

Parents: Married_____ **Single**_____ **Divorced**_____ **Separated**_____ **Widowed**_____
Patient Resides with: ( ) Father ( ) Mother ( ) Father & Mother ( ) Other
Patient's Father's Name_____**Social Security #**_____
Father's Address_____**Home Phone**_____
(Street) (City/State) (Zip) **Mobile Phone**_____
Business Phone_____
Father's Employer_____**Occupation**_____
Patient's Mother's Name_____**Social Security #**_____
Mother's Address_____**Home Phone**_____
(Street) (City/State) (Zip) **Mobile Phone**_____
Business Phone_____
Mother's Employer_____**Occupation**_____
Parents Email Address:_____

--Medical History--

Is Patient in good health?_____
Have tonsils and/or adenoids been removed?_____
If presently under physicians care, state condition and duration_____
_____
Does patient have history of major illness/infectious diseases?_____
List any high fevers with childhood diseases_____
List any drugs or medications being taken and reasons_____
_____
List any allergies or drug sensitivities (e.g.. penicillin, novacaine)_____
List any learning disabilities_____
List any birth defects_____
List any psychological counseling_____
Check any of the following for which you have been treated and give age:

	Yes	No		Yes	No		Yes	No
HIV + Aids…….	[ ]	[ ]	Bone Disorders……...	[ ]	[ ]	Kidney Problems……..	[ ]	[ ]
Fainting/dizziness…..	[ ]	[ ]	Pneumonia or TB…….	[ ]	[ ]	Nasal difficulty……..	[ ]	[ ]
Diabetes…….	[ ]	[ ]	Nervous Disorders…..	[ ]	[ ]	Heart Trouble…….	[ ]	[ ]
Epilepsy…….	[ ]	[ ]	Endocrine Problems..	[ ]	[ ]	Hepatitis……..	[ ]	[ ]
Rheumatic Fever……..	[ ]	[ ]	Asthma……..	[ ]	[ ]	Prolonged Bleeding…….	[ ]	[ ]
Dermatitis…….	[ ]	[ ]						

_____

--DENTAL HISTORY--

Did Father have an orthodontic problem?_____Treated?_____
Did Mother have an orthodontic problem?_____Treated?_____
Do any siblings have an orthodontic problem?_____Treated?_____
List other family members treated in this office_____
List names and ages of other children in family_____
Face and mouth most resemble: [ ]Father [ ]Mother [ ]Neither
List any injuries to face, teeth or mouth_____
Habits: [ ]Mouth breathing [ ]Grinding teeth [ ]Thumb or finger sucking (until what age)_____
List any speech problems_____
List any musical instruments played_____
Has an orthodontist been consulted previously: [ ]Yes [ ]No Whom?_____
Does patient vomit , gag or faint easily? [ ]Yes [ ]No
Have you been informed of any missing or extra permanent teeth? [ ]Yes [ ]No_____
Is patient especially apprehensive toward dental visits? [ ]Yes [ ]No
When did patient last have dental care?_____
By Whom_____When is next scheduled visit?_____
What do you feel may be the cause of the orthodontic problem?_____
What would you most like to have orthodontic treatment accomplish?_____
Most Important- does the patient want orthodontic treatment? [ ]Yes [ ]No

PATIENTS NAME:_____

--AUTHORIZATIONS—

I hereby authorize Dr. Richards to release a copy of my records to any treating physician/dentist, insurance company or other orthodontist, who may request these records pursuant to further medical or orthodontic care or treatment, and hereby release Dr. Richards and his staff, from any and all responsibility that may arise from their compliance with this authorization. I hereby authorize Dr. Richards to use any of my x-rays or photographs in medical lectures /publications and for further educational purposes. I understand the panorex taken at my new patient exam is at no charge but if the panorex is requested to leave our office there will be a $150 charge.

_____ _____

DATE **PATIENT OR PARENT/GUARDIAN'S SIGNATURE**

We have a website and a facebook page and would love to share your/your child's smile.

[ ] I do give Dr. Richards permissions to share my photos.

[ ] I do not give Dr. Richards permission to share my photos.

_____ _____

DATE **PATIENT OR PARENT/GUARDIAN'S SIGNATURE**