



Name: _____ E-mail Address: _____
 Patient's Address: _____ Telephone: _____
 Nickname: _____ Birth date: _____ Age: _____ Sex: _____
 School/Employer: _____ Grade/Position: _____
 Interest/Sports: _____

Primary Mother Father Step Parent Self Other (specify) _____
 Responsible Party: _____ Telephone: _____
 Address: _____ How Long? _____
 Employer/Address: _____ Telephone: _____
 Social Security Number: _____

Secondary Mother Father Step Parent Self Other (specify) _____
 Responsible Party: _____ Telephone: _____
 Address: _____ How Long? _____
 Employer/Address: _____ Telephone: _____
 Social Security Number: _____

How Did You Hear About Us? Dentist Patient Relative Acquaintance Other _____
 Whom May We Thank for Referring You To Us? _____ Present Dentist: _____
 Reason For Consultation: _____

Check Yes or No for which the patient has a history: **** Please notify us immediately if there are any changes to your medical history ****

	Y	N		Y	N		Y	N		Y	N
AIDS			Cancer			Endocrine Problems			Immune Problems		
Allergies			Cerebral Palsy			Emotional Disorders			Kidney Problems		
Anemia			Chest pains			Epilepsy			Low Blood Pressure		
Arthritis			Chronic Neck Pain			Fainting, Dizziness			Mouth Breathing		
Aspirin			Clicking of Jaw			Glaucoma			Muscular Disorders		
Asthma			Cold Sores/Herpes			Headaches			Nervous Disorders		
Autoimmune			Diabetes			Heart Condition			Organ Transplant		
Bone Disorders			Downs Syndrome			Hepatitis			Painful Chewing		
Bulimia			Drug allergies			High Blood Pressure			Periodontal Problems		
									Pneumonia		
									Pregnant		
									Prolonged Bleeding		
									Rheumatic Fever		
									Scoliosis		
									Seizures		
									Sicca		
									Speech Problems		
									TMJ/Jaw Problems		
									Tooth Grinding		
									Tuberculosis		
									Venereal Disease		
									Neck Aches		
									Heart Murmur		

If allergies, specify _____ Any disease or problems not mentioned above? _____ **Is medication required before dental visits?** _____
 Current Medications? _____
 Females: Have you started menstruating? _____ At what age? _____
 Have wisdom teeth been extracted? _____ Any face, mouth or teeth injuries? _____
 Does the patient normally breathe through the mouth while awake or asleep? _____ Do gums bleed when brushed or flossed? _____
 Has an orthodontist been consulted previously? _____ Have you ever had previous orthodontic treatment? _____
 Are there any missing or extra teeth? _____ Have the tonsils and adenoids been removed? _____
 Any other questions? _____
 Names and ages of brothers and sisters: _____

Insurance Information (Please fill out completely so we may properly file your insurance)

Name of Primary Orthodontic Insurance: _____ Telephone: _____
 Name of Policy Holder: _____ Mother Father Step Parent Self Other (specify) _____
 Policy Holder's Birthdate: _____

 Name of Secondary Orthodontic Insurance: _____ Telephone: _____
 Name of Policy Holder: _____ Mother Father Step Parent Self Other (specify) _____
 Policy Holder's Birthdate: _____

I acknowledge that I have reviewed the Notice of Privacy Practices for the office of Dr. Tisseront.

Signature: _____ **Relationship to Patient:** _____

Date: _____