Name:

Date:

Nickname: _____ Birth Date:_____ Sex:_____ E-Mail Address: _____ Home Phone: _____

Cell Phone: _____ Patient's Address_____

School/Employer: _____ Grade/Position:_____ Interests/Sports: _____

Names and Ages of Brothers and Sisters? _____

Primary Responsible Party: _____ Mother Father Step Parent Self Other (Specify)_____

Address:_____ Home Phone: _____ Cell Phone: _____

Employer/ Address: _____ How Long?: _____ Telephone: _____

Social Security Number: _____

Secondary Responsible Party:_____ Mother Father Step Parent Self Other (Specify): _____

Address:_____ Home Phone: _____ Cell Phone: _____

Employer/ Address: _____ How Long?: _____ Telephone: _____

Social Security Number: _____

How did you hear about us? Dentist Patient Relative Acquaintance Other: _____ Present Dentist? _____

Whom may we thank for referring you to us? _____ Reason for consultation? _____

Circle Yes or No for which the patient has a history

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

Primary Physician_____Telephone:_____Any diseases, problems, or allergies not mentioned above? _____

Current Medications? _____ Females: Have you started menstruating? **(Y/N)** At what age? _____ Do you Snore? **(Y/N)**

Do you suffer from sleep apnea? **(Y/N)** Do you often feel fatigued? **(Y/N)** Does the patient normally breathe through the mouth while awake or asleep? **(Y/N)**

Do gums bleed when brushed or flossed? **(Y/N)** Have wisdom teeth been extracted? **(Y/N)** Any face, mouth, or teeth injuries? **(Y/N)** _____

Has an orthodontist been consulted previously? **(Y/N)** Have you had previous orthodontic treatment? **(Y/N)** _____

Are there any missing or extra teeth? **(Y/N)** ____ Have the tonsils and adenoids been removed? **(Y/N)** Any other questions? _____

Please circle in order of importance (1 being most important and 4 being least important)

Least Noticeable Treatment 1 2 3 4 Function/Long-Term Health 1 2 3 4 Speed 1 2 3 4 Treatment Cost 1 2 3 4

Botox Patients Only: Have you had Botox before? **(Y/N)** If yes, when?_____ Are you pregnant? **(Y/N)** Are you currently nursing? **(Y/N)**
Are you allergic to Albumin? **(Y/N)**

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

Primary Insurance Information

Name of Primary Orthodontic Insurance: _____ Insurance Phone Number: _____

Policy Holder Name: _____ Mother Father Step Parent Self Other (Specify): _____

Policy Holder's DOB: _____ Subscriber ID: _____

Secondary Insurance Information

Name of Secondary Orthodontic Insurance: _____ Insurance Phone Number: _____

Policy Holder Name: _____ Mother Father Step Parent Self Other (Specify): _____

Policy Holder's DOB: _____ Subscriber ID: _____

I acknowledge that I have reviewed the Notice of Privacy Practice for the office of Dr. Tisseront. Phone calls and treatment consultations may be recorded for the purpose of improving customer service and staff training.

Signature: _____ Relationship to Patient: _____ Date: _____