Please COMPLETE ALL information. Thank you.

PATIENT INFORMATION

WELCOME TO OUR OFFICE! A B C

Patient # _____ Patient Age _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birth Date _____ Social Security # _____

If patient is a minor, give parent or guardian's name _____

Office location preference **(circle one)** Crown Point Schererville Merrillville Valparaiso

Responsible party e-mail address _____

How did you hear about our office? _____

RESPONSIBLE PARTY INFORMATION

Name _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Own or Rent

Previous address (if less than 3 years) _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security # _____ Birth Date _____ Relationship to Patient _____

Employer _____ Occupation _____ # years employed _____

Spouse's Name _____
Last First Middle Relationship to Patient

Marital Status _____ Spouse's Social Security # _____

Spouse's Mailing Address _____
Street City State Zip

Spouse's Employer _____ Occupation _____ # years employed _____

Spouse's Birth Date _____ Spouse's Work Phone _____

Spouse's Cell Phone _____

EMERGENCY INFORMATION

Name of Nearest Relative not living with you _____

Complete Address _____

Phone _____ Relationship to Patient _____

I understand that I will be responsible for all lab fees incurred in the fabrication of a splint or orthodontic appliance in the event that I choose not to continue treatment. I understand that it is policy of Puntillo & Crane Orthodontics that the parent who requests treatment for a minor child shall be responsible for all services rendered.

INITIAL _____

To enable us to better set the terms of credit for you or your child's care, today we will obtain the appropriate credit bureau reports.

Signature (Parent's signature if minor) _____

Date _____

Dental History

	YES	NO
Any dental pain or problems needing attention?	( )	( )
If **YES**, please describe. _____		
Have you every bumped, chipped, or fractured any teeth?	( )	( )
Do you snore?	( )	( )
Is it difficult to breathe through your nose?	( )	( )
Do you breathe with your mouth constantly open?	( )	( )

TMJ (Jaw Joint) History

	YES	NO
Do you or have you ever had a TMJ problem?	( )	( )
If **YES**, have you ever been treated?	( )	( )

By whom? _____

When? _____

Please describe your problem and/or concern:

_____

_____

I represent that all the statements and answers contained herein, are to the best of my knowledge and belief, complete, true and correctly recorded and it is agreed that **Puntillo and Crane Orthodontics P.C.**, and staff shall not be presumed to have knowledge of any information not so recorded.

Patient's
Signature: _____ Date: _____
(Parent if patient is a minor)

INSURANCE INFORMATION

Insured's Name _____DOB _____Insured's ID# _____
Insured's Address _____Ins Co. Phone_____
Insurance Company _____Group # _____
Insured's Employer _____
Do you have dual coverage? Yes ( ) No ( ) If yes, please continue: _____
Insured's Name _____DOB _____Insured's ID# _____
Insurance Company _____Group # _____
Insured's Address _____Phone_____
Insured's Employer _____

****Your answers are for office records only and are kept confidential. A thorough medical history is essential to a complete orthodontic evaluation.****

Medical History

Have you ever had any of the following? **Please circle YES or NO.**

Yes or No - Birth defects or hereditary problems

Yes or No - Any injury to the head, neck, or face

Yes or No - Endocrine or thyroid problems

Yes or No - Kidney problems

Yes or No - Radiation or chemotherapy

Yes or No - Immune system problems

Yes or No - Sexually transmitted disease

Yes or No - Hepatitis, jaundice, other liver problems

Yes or No - Seizures, fainting spells

Yes or No - Vision or hearing problems

Yes or No - High or low blood pressure

Yes or No - Chest pain, shortness of breath, tire easily

Yes or No - Heart defect, murmur, heart attack

Yes or No - Mitral Valve Prolapse, heart disease

Yes or No - Bone fractures or major injuries

Yes or No - Arthritis or joint problems

Yes or No - Diabetes or low blood sugar

Yes or No - Cancer, tumor

Yes or No - Stomach ulcer or acid reflux

Yes or No - Osteoporosis

Yes or No - AIDS or HIV positive

Yes or No - Polio, Mono, TB, or Pneumonia

Yes or No - Depression

Yes or No - History of Anorexia or Bulimia

Yes or No - Bruise easily, Anemia

Yes or No - Swollen ankles

Yes or No - Sickle Cell Disease

Yes or No - Stroke

Yes or No - Skin disorder (other than acne)

Yes or No - Asthma, sinus problems, hay fever

Yes or No - Tonsil or adenoid condition

Yes or No - Cold sores/fever blisters

Yes or No - Rheumatic Fever

Yes or No - Frequent headaches or migraines

Yes or No - Speech problem and/or therapy

Yes or No - Latex or Nickel sensitivity

Yes or No - Nervous/Anxious

Yes or No - Hemophilia, Excessive bleeding

	YES	**NO**
Are you currently undergoing any medical treatment?	( )	( )
If **YES**, for what? _____		
Who is your physician? _____		
Are you currently taking any medications?	( )	( )
If **YES**, please list all medications. _____		
Are you allergic to any medications?	( )	( )
If **YES**, please list. _____		
Do you have any allergies (for example: cats, milk, seasonal)?	( )	( )
If **YES**, please list. _____		
Are you pre-medicated for major dental work and cleanings?	( )	( )
Do you chew or smoke tobacco?	( )	( )
If you are a woman, are you pregnant?	( )	( )
Are there any other health problems not listed?	( )	( )
If **YES**, please describe. _____		

_____