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 ________

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. ______		

______

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?	( )	( )

Do you have any of the following habits? Please circle.
Thumb, finger, lip, or pacifier sucking, finger nail biting, biting other objects
Other ____________________

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)