NEW PATIENT INFORMATION FORM

Thank you for choosing our office. We need to gather some additional information that will take about five minutes.

Name: ____ Responsible party:______________________________
Home Phone: _________________Cell Phone: ___________________ email: ___________________________
Address:____

- How did you hear about our office?
  _____Referring office
  _____Family
  _____Friend
  _____Internet
  _____Sign, flyer, postcard
- Do you have any friends or family members that are patients? ______________ If yes, who? ____
- May We have your (child's) name?____
- May We have your (child's) date of birth?____
- Who is your (his/her) general dentist? ____

We will be happy to contact Dr. _______________________________'s office and let them know you have made an appointment and how much we appreciate their referral. We will also see the date of your (or the child's name) last cleaning and x-rays.

Please answer yes or no to the following questions regarding your (child's) dental health:

Have any teeth been removed byextraction?____ YES NO
Was it suggested that the space be maintained?_______________________________________ YES NO
Was an appliance placed?______________ ____YES NO
Do you breathe mainly through the mouth (are the lips usually parted)___________________YES NO
Have you ever had a habit of thumb/finger sucking, tongue thrust, or lip biting? ___________ YES NO
Have you noticed any speech problems? ____ YES NO
Have you noticed any difficulty chewing food? ____YES NO
Are you aware of grinding or clenching your teeth?____ ________________________________ YES NO
Are you aware of any missing or extra teeth? ____ YES NO
Are you dissatisfied with the appearance of your teeth or other facial structures? ___________YES NO
Are you sensitive regarding statements concerning your facial/teeth appearance? ___________YES NO
Is this your first visit to the orthodontist? ____YES NO

- What particular concerns do you have about your teeth? ____
  ____