Welcome To Our Office

PATIENT HISTORY FORM (must be completely filled out)

PATIENT INFORMATION

Patient Name_____Date of Birth_____ Sex: M F Marital Status: M D S W

Home Phone No.:_____ Work Phone:_____Cell Phone:_____

Social Security No.:_____Driver's License No.:_____Spouse'sName:_____

StreetAddress_____City:_____State:_____ZipCode:_____

Dentist:_____ Patient's Physician:_____

E-Mail:_____Hobbies:_____

IF PATIENT IS A MINOR

Mother's Name:_____ Social Security No.:_____ E-Mail:_____

Address (if different from patient):_____ City:_____State:_____ Zip Code:_____

Mother's Employer:_____ Business Phone:_____ Cell Phone:_____

Father's Name:_____ Social Security No.:_____ E-Mail:_____

Address (if different from patient)_____ City:_____State:_____ Zip Code:_____

Father's Employer:_____ Business Phone:_____ Cell Phone:_____

Parents marital status: married divorced separated widowed Do parents live together at same address: yes no

RESPONSIBLE PARTY INFORMATION (If Other Than Patient)

Name:_____ Social Security No.:_____ Driver's License No.:_____

Date of Birth:_____ Relationship to Patient:_____ Home Phone No.:_____ Cell Phone:_____

Street Address (No P.O. Box unless mail delivery only at P.O. Box):_____

City:_____ State:_____ Zip Code:_____ How Long at This Address: _____Years _____Months

EMPLOYER INFORMATION (Responsible Party)

Employer:_____ Occupation:_____ Business Phone:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Years at Employer:_____Years_____Months

Spouse's Employer:_____ Occupation:_____ Business Phone:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Years at Employer:_____Years_____Months

DENTAL INSURANCE INFORMATION

Insurance will not be filed without complete information including addresses

Subscriber's Name:_____ID Number:_____ Date of Birth:_____

Insurance Company:_____ Group No:_____

Insurance Phone Number:_____ Insured's Employer:_____

Employer Address:_____City:_____St.:_____Zip:_____

EMERGENCY INFORMATION

Person to Contact:_____ Relationship to Patient:_____ Phone No.:_____

Address:_____ City:_____ State:_____ Zip Code:_____

(COMPLETE OTHER SIDE)

PATIENT'S MEDICAL HISTORY

Have you been under the care of a physician in the last two years: _____ Have you ever had or do you now have any of the following:

___Prolonged Bleeding
___Epilepsy
___Diabetes
___Heart Problems
___Rheumatic Fever
___Bone Disorders
___Tuberculosis
___Hepatitis (any form)
___AIDS or HIV
___Osteoporosis
___Cancer
___Anemia
___Asthma
___Fainting or Dizziness
___Nervous Disorder
___Endocrine Problems
___Liver Problems
___Birth Defects
___Allergies

Have you had any operations in the past 2 yrs. YES NO
Explain:_____
Have you been hospitalized in the past 2 yrs. YES NO
Explain:_____

List any medications you are on:
_____
_____
_____

Please explain medical conditions:
_____
_____

Are you allergic to any medications: YES NO Please List:_____

PATIENT'S DENTAL HISTORY

Do you have any of the following:

_____Any family members who have had orthodontics.
_____Any family members who have had orthodontics here at Brazos Braces.
Name(s):_____

_____Teeth sensitive to hot/cold.
_____Injuries to face, jaw, mouth or teeth.
_____Bleeding gums, bad taste in mouth.
_____Root canals, crowns, or bridges.
_____Suck your thumb and/or fingers.
_____Any clicking, popping or pain of the jaw, joints (TMJ).
_____Any missing teeth or extra teeth.
_____Trouble chewing.

Date of most recent dental exam:_____
How often do you brush your teeth:_____
How often do you floss your teeth:_____

Your signature below gives Dr. Bryan E. Taylor, and /or Dr. Danielle Geshay permission to treat the above named patient at the initial examination. If comprehensive treatment is begun, you will sign and be given a detailed informed consent.

I hereby consent to the making of diagnostic records, including x-rays, before during and the following orthodontic treatment, and to the above doctor(s) and, where appropriate, staff providing orthodontic treatment prescribed by the above doctor(s) for the above individual. I fully understand all of the risks associated with the treatment.

_____SIGNATURE **(if patient is a minor, PARENT/GUARDIAN must sign)**

_____SIGNATURE OF ORTHODONTIST

_____TODAY'S DATE

Updates: (Date and Initial)_____ Updates: (Date and Initial) _____