RYAN COX
ORTHODONTICS

Patient Information

Today's Date _____ ☐ Male ☐ Female

Name _____
Last First MI

Name Preferred _____

Date of Birth _____ Age _____

Address _____

City _____ State _____ Zip _____

School _____

Patient's Hobbies/Interests _____

Responsible Party Information

Name _____

Relationship to Patient _____

Address _____

City _____ State _____ Zip _____

Employer _____

☐ Cell / ☐ Home # _____

Work # _____

☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed

Responsible Party's E-mail

_____

Name _____

Relationship to Patient _____

Address _____

City _____ State _____ Zip _____

Employer _____

☐ Cell / ☐ Home # _____

Work # _____

☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed

Responsible Party's E-mail

_____

Medical/Dental History

General Dentist _____

Last Dental Visit _____

Is the patient under the care of a physician for a specific reason at this time? _____

Physician's Name _____

Are you taking any prescription medication?

☐ Yes ☐ No If so, which ones? _____

Are you taking medications for osteoporosis or osteopenia?

☐ Yes ☐ No

List any drug sensitivities _____

Adolescent patients only

Has the patient reached puberty? ☐ Yes ☐ No

Please check all of the following that apply

☐ Diabetes ☐ TMJ Pain ☐ Heart Condition
☐ Epilepsy ☐ Bone Disorders ☐ Kidney Problems
☐ Hepatitis ☐ AIDS/HIV

Have you been informed of any missing/extra teeth?

☐ Yes ☐ No

Are there any other family members that you would like us to evaluate? ☐ Yes ☐ No

_____

Family members previously treated at our office?

_____

Who may we thank for referring you to our office?

_____

Insurance

Primary Dental Insurance

Insured's Name _____

Employer _____

Insurance Company _____

Date of Birth _____ SS # _____

Secondary Dental Insurance

Insured's Name _____

Employer _____

Insurance Company _____

Date of Birth _____ SS # _____

X _____

Signature of Parent/Patient/Guardian **Date**