Taylor
Family Orthodontics

Date ______________________

Name or nickname patient prefers to be called ____

Whom may we thank for referring you to our office? ____

Has someone you know been treated by us? Name/relation? ____________________________________

Patient Information

Name____ Email______________________________
Last First Middle

Age (yrs/mo's) ____________________ Birth date ____________________________ Sex : M F

Address ____ City _____________________ ZIP __________

Phone: Home ______________________ Cell _______________________ Work ______________________

Interests, talents, sports or hobbies? ____

Guardian's Names ______________________________________ Emergency Phone #________________
Mother Father

Person Financially Responsible

Name____ Email ______________________________
Last First Middle

Address ____ City _____________________ ZIP __________

Birth date _______________ SSN _____________________ Relation to Patient _________________________

Phone: Home ______________________ Work _______________________ Cell ______________________

Occupation ________________________ Employer _____________________________ Yrs at company _____

Dental Insurance Information

Primary Ins. Co. ____________________________ Group # _____________ Subscriber # ____________________

Insured's Name ____ Insured's SSN ______________________
Last First Middle

Secondary Ins. Co. _________________ ________ Group # _______________ Subscriber # ____________________

Insured's Name ____ Insured's SSN ______________________

Dental and Medical History

Please describe the orthodontic problem or what about your mouth or smile you want changed:

____

Family Dentist ____________________________ City ______________________ Date of last visit ___________

Please circle if you have or had any of the following:

Allergies (please list below)	Hepatitis	Tuberculosis	High Blood Pressure / Heart Prob
HIV/AIDS	Headaches	Seizures	Asthma / Difficulty Breathing
Trauma to teeth or face	Bleeding problems	Hospitalization (non maternity)	
Thumb-sucking habit	Missing or extra teeth	Tongue Thrust	Noise or pain in jaw joint

List other medical conditions____

Current medications____

Allergies ____

I certify the information above is accurate to the best of my knowledge. I understand the information will be used by the orthodontist to help determine appropriate treatment. I will notify Dr Taylor of any change in my medical or dental status. I understand that treatment plans involving extended credit may require a credit check on my credit rating.

Signature ____ ***Date*** ______________________