Weber ORTHODONTICS

Today's Date:_____ Account #:_____

PATIENT INFORMATION

Name:_____
Last First Middle Nickname

Birthday:_____/_____/_____ Age:_____ Female/Male _____
Month Day Year

Home Address:_____
Street City State Zip

Home Phone: (____)_____Cell Phone :(____)_____Email:_____

**Please check Preference for appointment reminders*:
text_____ (wireless carrier)_____ or email_____

Dentist: _____ School Attending:_____

List any injury to the teeth, head or face:_____

Thumb Sucker/Tongue Thruster as child:_____ Pain or clicking jaw joint?_____

Please list any allergies:_____
Tonsils removed? _____

Please indicate which of the following the patient has been treated for:

Yes/ No	Diabetes	Yes/ No	Auto Immune Disease	Yes/ No	Prolonged Bleeding
Yes/No	Pneumonia	Yes/No	Tuberculosis	Yes/No	Kidney Involvement
Yes/No	Heart Trouble	Yes/No	Fainting/Dizziness	Yes/No	Endocrine Problems
Yes/No	Rheumatic Fever	Yes/No	Epilepsy	Yes/No	Liver Involvement
Yes/No	Asthma	Yes/No	Bleeding	Yes/No	Nervous Disorders
Yes/No	Bone Disorders	Yes/No	Anemia		

Hobbies/Special Interests:_____

Previous Orthodontic Consultations or Treatments:_____
Where When

Any relatives treated in our office:_____

Referred to our office by:_____
Name(s)

Parent/Guardian Signature:_____ **Date**:_____

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RESPONSIBLE PARTY INFORMATION

1st Party 2nd Party (if needed)

Name:

SSN:

Relation to Patient:

Street Address:

City, State, Zip:

Home Phone/ Cell Phone:

ORTHODONTIC INSURANCE INFORMATION

Dental Insurance (Primary)
(Not Medical)

Employee Name:

Employee SSN/ID# DOB:

Employer:

Group #

Insurance Phone #

Dental Insurance (Secondary)

Employee Name:

Employee SSN/ID# DOB :

Employer :

Group #