DR. GLENN F. PERRIN *Certified Specialist in Orthodontics*

NEW PATIENT INFORMATION **PATIENT #**

PLEASE PRINT & COMPLETE BOTH SIDES OF FORM

Send via email

DATE:_____ 20 ____

PATIENT FULL NAME:_____

DOES THE PATIENT GO BY A NICKNAME?: _____ ☐ MALE ☐ FEMALE

PATIENT AGE:_____ DATE OF BIRTH:_____ HOME PHONE: _____

STREET ADDRESS_____

CITY:_____ PROV/STATE:_____ POSTAL/ZIP CODE: _____

WHO WILL BE RESPONSIBLE FOR THIS ACCOUNT?

☐ SELF, ☐ PARENTS, ☐ FATHER, ☐ MOTHER, ☐ OTHER_____

RESPONSIBLE PARTY NAME (if not self): MR/MRS/MS/DR _____

RESPONSIBLE PARTY SPOUSE NAME: MR/MRS/MS/DR _____

RESPONSIBLE PARTY STREET ADDRESS **(if different)**: _____

CITY:_____ PROV/STATE:_____ POSTAL/ZIP CODE: _____

RESPONSIBLE PARTY HOME PHONE:_____ WORK PHONE: _____

RESPONSIBLE PARTY OCCUPATION:_____ EMPLOYER: _____

PATIENT'S SCHOOL:_____ GRADE:_____

DO YOU HAVE ANY OTHER FAMILY MEMBERS THAT HAVE BEEN TREATED AT OUR OFFICE?

NAMES: _____

DO YOU HAVE ORTHODONTIC INSURANCE?

☐ YES, ☐ NO COVERAGE PERCENTAGE:_____% LIFETIME LIMIT: _____

WE DO NOT BILL DENTAL INSURANCE COMPANIES OR OTHER THIRD PARTIES ON PATIENT'S BEHALF. ACCORDINGLY, WE WILL EXPECT THAT PAYMENT BE RECEIVED DIRECTLY FROM PATIENTS AS SERVICES ARE PROVIDED. WE WILL BE PLEASED TO PREPARE REPORTS AND CLAIMS FOR *YOU* TO SUBMIT TO INSURANCE COMPANIES FOR REIMBURSEMENT UPON RECEIPT OF PAYMENT FOR SERVICES RENDERED.

WERE YOU REFERRED TO OUR OFFICE BY YOUR FAMILY DENTIST? ☐ YES, ☐ NO

WERE YOU REFERRED BY SOMEONE ELSE? ☐ YES, ☐ NO, **WHOM?** _____

DENTAL HISTORY

DENTIST'S NAME:_____ LAST VISIT?: _____

HAVE THERE BEEN ANY INJURIES TO THE FACE OR MOUTH?: ☐ YES, ☐ NO, PLEASE EXPLAIN: _____
_____

HAS THE PATIENT EVER HAD AN ORAL HABIT (THUMB, FINGER, SOOTHER, FINGERNAILS)?: ☐ YES, ☐ NO

WHAT AGE WAS THE HABIT STOPPED?:_____ DOES THE PATIENT HAVE A TONGUE THRUST?: ☐ YES, ☐ NO

DOES THE PATIENT HAVE ANY SPEECH PROBLEMS?: ☐ YES, ☐ NO, PLEASE EXPLAIN:_____
_____

DOES THE PATIENT HAVE A DIFFICULT TIME BREATHING THROUGH THEIR NOSE?: ☐ YES, ☐ NO

RATE THE PATIENT'S ORAL HYGIENE: ☐ GOOD, ☐ FAIR, ☐ POOR. FLOSSING?: ☐ YES, ☐ NOT REGULAR

MEDICAL HISTORY

PHYSICIAN'S NAME:_____ PHONE: _____

IS PATIENT IN GOOD HEALTH?: ☐ YES, ☐ NO **WOMEN, ARE YOU PREGNANT?:** ☐ YES, ☐ NO, DUE? _____

IS PATIENT PRESENTLY UNDER A PHYSICIAN'S CARE?: ☐ YES, ☐ NO, WHY?:_____
_____

DOES THE PATIENT HAVE A HISTORY OF ANY MAJOR ILLNESS?: ☐ YES, ☐ NO, EXPLAIN: _____
_____

DOES THE PATIENT SNORE?: ☐ YES, ☐ NO ANY PROBLEMS WITH TONSILS OR ADENOIDS?: ☐ YES, ☐ NO

HAVE TONSILS AND/OR ADENOIDS BEEN REMOVED?: ☐ YES, ☐ NO, WHAT AGE?: _____

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN: _____
_____

GIVE REASON FOR MEDICATION: _____
_____

LIST ANY ALLERGIES OR DRUG SENSITIVITY:_____
_____

DOES THE PATIENT WEAR CONTACT LENSES?: ☐ YES, ☐ NO DOES THE PATIENT SMOKE?: ☐ YES, ☐ NO

DOES THE PATIENT HAVE A HISTORY OF ANY OF THE FOLLOWING PROBLEMS?:
☐ DIABETES, ☐ RHEUMATIC FEVER, ☐ BONE/GROWTH DISORDERS, ☐ THYROID DISEASE, ☐ EPILEPSY

PLEASE EXPLAIN:_____

I UNDERSTAND THAT THE INFORMATION I HAVE GIVEN IS CORRECT, THAT IT WILL BE HELD IN STRICTEST CONFICENCE, AND IT IS MY RESPONSIBILTY TO INFORM THIS OFFICE OF ANY CHANGES. I AUTHORIZE THE ORTHODONTIC STAFF TO PERFORM NECESSARY DIAGNOSTIC AND ORTHODONTIC PROCEDURES.

SIGNATURE OF RESPONSIBLE PARTY: _____