Welcome to Our Office!

Confidential Patient Information

Patient's Name: Last _____First_____Middle_____ Sex: M ☐ F ☐

Address: Street_____City_____State_____Zip _____

Home Phone _____Birthdate_____Social Security # _____

If patient is a minor, give parents's or guardian's name_____

Hobbies/Interests _____

School_____ Grade: _____

Other family members seen in our office _____

Whom can we thank for referring you to our office? _____

Confidential Responsible Party Information

Name Last _____First_____Middle _____Marital Status _____

Residence:Street _____ City _____ State _____ Zip _____

Mailing Address Street_____City_____State _____Zip _____

How long at this address _____ Home Phone_____Work phone_____

Previous Address (if less than 3 years) Street_____City_____State_____ Zip _____

Social Security # _____Birthdate_____Relationship to Patient _____

Employer _____Occupation_____No. Years Employed _____

Spouse's Name Last_____ First _____Middle_____Relationship to Patient _____

Employer _____Occupation_____No. Years Employed _____

Social Security #_____Birthdate_____Work Phone _____

Insurance Information

Policy Holder's Name_____Soc. Sec. # _____

Insurance company _____Group No. _____Union Local No __

Insurance Co. Address _____Insurance Co. Phone _____

Policy Holder's Employer _____ _____

Do you have dual coverage? No_____ Yes ____ If yes: _____

Policy Holder's Name _____and Soc. Sec. #_____

Insurance Company _____Group No. _____Union Local No _____

Insurance Co. Address _____Insurance Co. Phone _____

Policy Holder's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete address _____

Phone _____Relationship_____

Dental History

Name of general dentist _____City/State_____
Date of last dental visit _____ Date of last dental x-rays_____
Chief orthodontic complaint _____
Please describe any previous orthodontic treatment or examinations: _____

Please check if you have had any of the following:

☐ Bad breath	☐ Loose teeth / broken filling	☐ Sensitivity to sweets
☐ Bleeding gums	☐ Mouth breathing / snoring	☐ Sensitivity when biting
☐ Clicking, popping or pain in jaw	☐ Nail Biting	☐ Soreness or pain in muscles of face
☐ Food collection between teeth	☐ Periodontal treatment	☐ Sores or growths in mouth
☐ Grinding teeth	☐ Sensitivity to cold	☐ Thumb / digit sucking
☐ History of Jaw Joint Disorder (TMJ)	☐ Sensitivity to heat	☐ Whiplash Injury

History of thumb or finger habit? Until what age? _____

Medical History

Physician's Name _____ Date of last visit_____
List any serious illnesses or operations _____
If you have ever had a blood transfusion, give approximate date_____
Check if you have had any of the following:

☐ AIDS	☐ Cortisone Treatments	☐ Hepatitis	☐ Rheumatic Fever
☐ Anemia	☐ Cough, Persistent	☐ High/Low Blood Pressure	☐ Scarlet Fever
☐ Arthritis, Rheumatic	☐ Cough up blood	☐ HIV Positive	☐ Shortness of Breath
☐ Artificial Heart Valves	☐ Diabetes	☐ Jaw Pain	☐ Skin Rash
☐ Artificial Joints	☐ Epilepsy	☐ Kidney Disease	☐ Stroke
☐ Asthma	☐ Fainting	☐ Liver Disease	☐ Swelling of Feet
☐ Back Problems	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Thyroid Problems
☐ Blood Disease	☐ Headaches	☐ Nervous Problems	☐ Tobacco Habit
☐ Cancer	☐ Heart Murmur	☐ Pacemaker	☐ Tonsillitis
☐ Chemical Dependency	☐ Heart Problems	☐ Psychiatric Care	☐ Tuberculosis
☐ Chemotherapy	☐ Hemophilia	☐ Radiation Therapy	☐ Ulcer
☐ Circulatory Problems		☐ Respiratory Disease	☐ Venereal Disease

☐ Other _____

Women: Pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No Taking birth control pills? ☐Yes ☐No

Medications:

List all medications you are currently taking:

_____

_____

Allergies or Drug Reactions:

List all known or possible allergies:

_____

_____

Authorization

I have read and answered the above questions to the best of my knowledge. If there are any changes to this history record or medical/dental status I will inform this practice. I authorize and request my insurance company to pay directly to Dr. Cusack's office insurance benefits otherwise payable to me. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that credit bureau reports may be obtained where appropriate. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature of parent or guardian Date