



Welcome to Our Office!

Confidential Patient Information

Patient's Name: Last _____ First _____ Sex: ___M___F
Address: Street _____ City _____ State _____ Zip _____
Home Phone _____ Birthdate _____ Social Security # _____
*Hobbies or Interests? _____
School _____ Grade: _____
Other family members seen in our office? _____
Whom can we thank for referring you to our office or how did you find us? _____

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 _____ Phone _____
Complete address _____ 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:

- | | | |
|--|---|--|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Loose teeth / broken filling | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Mouth breathing / snoring | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Clicking, popping or pain in jaw | <input type="checkbox"/> Nail Biting | <input type="checkbox"/> Soreness or pain in muscles of face |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sores or growths in mouth |
| <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Thumb / digit sucking |
| <input type="checkbox"/> History of Jaw Joint Disorder (TMJ) | <input type="checkbox"/> Sensitivity to heat | <input type="checkbox"/> 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:

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

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

****Have you ever taken bisphosphonate drugs (Fosamax, Boniva, Actonel, Zomida, etc used to treat osteoporosis or multiple myeloma)? ___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. Insurance benefit calculations are estimates only and your responsibility to verify. I understand that I am financially responsible for all charges whether or not paid by insurance for any reason. 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