



Welcome to i-Orthodontics!
We are so excited you chose *us* for
your Orthodontic needs!
#LiveLifeSmiling

Today's Date: _____

Patient Name: _____
First Middle Last (Nickname)

Birthdate: ____/____/____ Age: _____ Male Female

Appointment Reminders: Text Email Both

Best Phone #: (____) _____ Email Address: _____

Address: _____

CITY STATE ZIP
General Dentist: _____ Last Date Seen by General Dentist: _____

Who may we thank for referring you?: _____

List family members that are currently in our practice?: _____

Has the patient had previous Orthodontic Treatment? Yes No

What are your chief complaints you would like to discuss with Dr. Pfeffer?: _____

Has the patient ever had the following medical problems?

- | | | |
|-------------------------------------|--------------------------------------|------------------------------------|
| Y N Abnormal Bleeding | Y N Allergies to any drugs | Y N Any Hospital Stays |
| Y N Any Operations | Y N Asthma | Y N Cancer |
| Y N Congenital Heart Defect | Y N Convulsions / Epilepsy | Y N Diabetes |
| Y N Handicaps / Disabilities | Y N Hearing Impairment | Y N Heart Murmur |
| Y N Hemophilia | Y N Hepatitis | Y N HIV+ / AIDS |
| Y N Kidney / Liver Problems | Y N Rheumatic / Scarlet Fever | Y N Tuberculosis (TB) |
| Y N Frequent Colds | Y N Frequent Sore Throats | Y N High/Low Blood Pressure |

Please discuss any medical problems that the patient has

had: _____

Has the patient had any injuries to the face, mouth, or teeth? Yes No If yes, please explain: _____

Please list all drugs that the patient is currently taking: _____

Please list all drugs/materials that the patient is allergic to: _____

Has the patient ever has any pain/tenderness in his/her jaw joint (TMJ / TMD)? Yes No

Does the patient have the following habits? If yes, till what age?: _____

Y N Lip Sucking / Biting **Y N** Nail Biting **Y N** Nursing Bottle Habits **Y N** Thumb / Finger Sucking

For Women: Are you pregnant? **Y N** Are you nursing? **Y N** Are you using birth control? **Y N** Has menstruation started? **Y N**

Responsible Party Information

Mother's Name: _____

Birthdate: ____/____/____

Cell #: (____) _____

Work #: (____) _____ Ext.: _____

SS #: _____

Occupation: _____

Step Mother Guardian

Father's Name: _____

Birthdate: ____/____/____

Home #: (____) _____

Work #: (____) _____ Ext.: _____

SS #: _____

Occupation: _____

Step Father Guardian

Parent's Marital Status: Single Married Widowed Divorced Separated

Who is financially responsible for charges?: _____
Name Relation to Patient

If different from above, Billing address: _____

_____ CITY STATE ZIP

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local, or Policy #): _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Policy Owner's Name: _____

First Middle Last

First Middle Last

Relationship to Patient: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____

Policy Owner's Birthdate: ____/____/____

SS#: _____

SS#: _____

Policy Owner's Employer: _____

Policy Owner's Employer: _____

Orthodontic Coverage? Yes No

Orthodontic Coverage? Yes No