PRITCHARD
ORTHODONTICS
Tyler Pritchard D.D.S M.S.

Patient Information

Thank you for taking a moment to complete this form.
This information is needed in order to provide
you with the best possible treatment.
All patient information remains confidential.

Date: _______ / _______ / _______

1. Name ____ Age ________
LAST FIRST MIDDLE

Address ____ Phone ________________
STREET CITY STATE ZIP

Alternate Phone ____________________ E-mail ____________________ Birthdate _______ / _______ / _______

School/Employment ____________________________ Social Security # ____________________
(Adult employee please complete section 2)
Siblings ____ Grade ________________

Who may we thank for referring you to our office? ____

Describe your orthodontic/TMJ concerns: ____

2. EMPLOYMENT / FAMILY INFORMATION

Father/ Husband/ Self Name ____________________________ Social Security # ________________

Employed by ____________________________ How long _______ Occupation ________________

Mailing Address ____ Phone ________________

Mother/ Wife/ Self Name ____________________________ Social Security # ________________

Employed by ____________________________ How long _______ Occupation ________________

Mailing Address ____ Phone ________________

3. FINANCIAL INFORMATION

Do you have orthodontic insurance ☐ Yes ☐ No If yes, please complete the following:

1st Coverage ____ ________________
Employee Name Employee SS# Employee Birth Date

____ ________________
Employer Insurance Company Policy/Group Number

____ ________________
Employee Address (if different from patient) Phone (if different from patient)

2nd Coverage ____ ________________
Employee Name Employee SS# Employee Birth Date

____ ________________
Employer Insurance Company Policy/Group Number

____ ________________
Employee Address (if different from patient) Phone (if different from patient)

(Please continue on back)

4. MEDICAL HISTORY (Please check Yes or No. If Yes, please fill in details.)

Physician ______________________________ Phone ______________

☐ Yes ☐ No Are you allergic to any medications, latex or metal? ______________

☐ Yes ☐ No Are you currently taking any medication? ______________

☐ Yes ☐ No Do you have a history of major illness? ______________

☐ Yes ☐ No Have you had any operations or accidents? ______________

Please check any of the medical conditions below that you have had or currently have:

☐ AIDS	☐ Anemia	☐ Arthritis	☐ Asthma or Hay Fever	☐ Bone Disorders	☐ Diabetes
☐ Dizziness	☐ Epilepsy	☐ Gastrointestinal Disorders	☐ Heart Problems	☐ Hepatitis	☐ Herpes
☐ High Blood Pressure	☐ Kidney Involvement	☐ Liver Involvement	☐ Nervous Disorders	☐ Pneumonia	
☐ Prolonged Bleeding	☐ Rheumatic Fever	☐ Tuberculosis	☐ Tumor or Cancer		

Are there any medical conditions we have not discussed that you feel should be aware of? ______________

____

5. EMERGENCY INFORMATION

Name of nearest relative not living with you ______________ Relationship ______________

Address ______________________________ Phone ______________

6. DENTAL HISTORY (Please check Yes or No. If Yes, please fill in details.)

Dentist ______________________________ Date of Last Visit ______________

What concerns you most about your teeth?

☐ Yes ☐ No Are you presently in any dental pain? ______________

☐ Yes ☐ No Have you ever experienced any unfavorable reaction to dentistry? ______________

☐ Yes ☐ No Have you ever lost or chipped any teeth? ______________

☐ Yes ☐ No Have there ever been any injuries to face, mouth or teeth? ______________

☐ Yes ☐ No Do your gums bleed when you brush? ______________

☐ Yes ☐ No Do you have any pain or soreness around your face, neck or back? ______________

☐ Yes ☐ No Are your teeth or jaws ever uncomfortable when you awaken in the morning? ______________

☐ Yes ☐ No Are you aware of your jaw clicking or popping? ______________

☐ Yes ☐ No Have you ever been told you grind your teeth? ______________

☐ Yes ☐ No Do you have “tension” headaches, ear, eye or sinus problems? ______________

☐ Yes ☐ No Are you aware that some appointments will be during school/work hours? ______________

7. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this Acknowledgment

I, ______________________________, have recieved a copy of this office’s Notice of Privacy Practices.

______________________________ ______________

Signature Date

Patient/Parent ______________________________ Date ______________