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: ______ / ______ / ______

Name ____ Age ______________
LAST FIRST MIDDLE

Address ____ Email ______________________
STREET CITY STATE ZIP

Please Indicate either Home, Mom/ Dad/ Patient Cell: (____) ______________________ Alternate Phone (____) ______________________

Birthdate ________ / ________ / ________

School/Occupation ______________________________________ Social Security # ______________________

Siblings ____ Grade ______________________

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

FAMILY INFORMATION

Father's (or husband's) Name ______________________________________ Social Security # ______________________

Employed by ______________________________ How long __________ Occupation ______________________

Mailing Address ____Phone ______________________

Mother's (or wife's) Name ______________________________________ Social Security # ______________________

Employed by ______________________________ How long __________ Occupation ______________________

Mailing Address ____Phone ______________________

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)

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 currency have:

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

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

____

EMERGENCY INFORMATION

Name of nearest relative not living with you ____________________ Relationship ____________________

Address ______________________________ Phone ____________________

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 ☐ Are you presently in any dental pain? ______________________________

☐ Yes ☐ Have you ever experienced any unfavorable reaction to dentistry? ______________________________

☐ Yes ☐ Have you ever lost or chipped any teeth? ______________________________

☐ Yes ☐ Have there ever been any injuries to face, mouth or teeth? ______________________________

☐ Yes ☐ Do your gums bleed when you brush? ______________________________

☐ Yes ☐ Do you have any pain or soreness around your face, neck or back? ______________________________

☐ Yes ☐ Are your teeth or jaws ever uncomfortable when you awaken in the morning? ______________________________

☐ Yes ☐ Are you aware of your jaw clicking or popping? ______________________________

☐ Yes ☐ Have you ever been told you grind your teeth? ______________________________

☐ Yes ☐ Do you have "tension" headaches, ear, eye or sinus problems? ______________________________

☐ Yes ☐ Are you aware that some appointments will be during school/work hours? ______________________________

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this Acknowledgment

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

______________________________ ____________________

Signature *Date*

Patient/Parent ____________________ Date ____________________