PRITCHARD
ORTHODONTICS

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Tyler Pritchard D.D.S M.S.

Patient Information

Thank you for completing this entire 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 Subscriber ID/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 Subscriber ID/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 Have you taken or are you taking any medications for Osteoporosis, ie: Fosamax, Actonel, Boniva, Skelid, Didronel?

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

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

Previous mouth surgeries? _____

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 ☐ No Are you presently in any dental pain? _____

☐ Yes ☐ No Have you ever experienced any sleep apnea, trouble sleeping or snoring? _____

☐ 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 Have you been diagnosed with problems with your Tonsils, Uvula, Pharynx or airway opening?_____

☐ 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? _____

ACKNOWLEDGEMENT OF RECIEPT 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 _____