great smiles ORTHODONTICS
Dr. Savage & Dr. Weissman

Date _____

PATIENT INFORMATION

Last Name	First Name	Nickname	S.S. Number	Sex	Date of Birth	Age

Address	City	State	Zip

Email Address	Add to mailing list? Yes ☐ No ☐	Home Phone	Cell Phone

Employed By/Occupation	Business Address	Business Phone

single ☐ married ☐ sep ☐ divorced ☐ widow(er) ☐	Spouse's Name	S.S. Number	Date of Birth

Spouse Employed By/Occupation	Business Address	Cell Phone	Business Phone

Referred By	Name of General Dentist	Date of Last Visit

Related patients that are or have been under our care	Names and ages of children

INFORMATION ABOUT PERSON RESPONSIBLE FOR THIS ACCOUNT

Name	Relationship to Patient	Employed By/Occupation

Billing Address	City	State	Zip	Home #

Work # _____

Do you have orthodontic insurance? Yes ☐ No ☐ Name of Company? _____ Policy # _____

MEDICAL HISTORY

Please check any of the following conditions or problems you have experienced.

Aids/HIV ☐	Diabetes ☐	Fainting or Dizziness ☐	Kidney Trouble ☐
Anemia ☐	Emotional Disorder ☐	Fever Blisters ☐	Liver Trouble ☐
Artificial joints/valves ☐	Endocrine (hormone) ☐	Hearing ☐	Mumps ☐
Asthma ☐	Epilepsy ☐	Heart Murmur ☐	Mitral Valve Prolapse ☐
Bone Fractures ☐	Excessive Bleeding ☐	Heart Trouble ☐	Rheumatic Fever ☐
Convulsions ☐	Eye ☐	Hepatitis ☐	Speech Disorder Tuberculosis ☐

Other _____

Are you in good health? If no, please explain: _____ Yes ☐ No ☐

Do you have any history of major illness? _____ Yes ☐ No ☐

Are you currently under the care of a physician? Physician's name: _____ Yes ☐ No ☐

List any drugs or medications now being taken. Give reasons. _____

List any allergies or drug sensitivity. _____

DENTAL HISTORY

What are the main concerns that you would like orthodontics to accomplish? _____

Have you ever had or been evaluated for orthodontic treatment? _____ Yes ☐ No ☐

Have you ever had any injuries to your face, mouth, or teeth? _____ Yes ☐ No ☐

Have you ever experienced pain or discomfort in your jaw joint? (TMJ/TMD)? _____ Yes ☐ No ☐

Have you ever been informed of any missing or extra permanent teeth? _____ Yes ☐ No ☐

Do you have any speech problems? _____ Yes ☐ No ☐

To the best of my knowledge, the above information is complete and correct. I give my permission for any photographs, x-rays, or study models to be used for displays at scientific meetings, presentations and publications of a scientific nature or for study group purposes to further the art and science of orthodontics. I, the undersigned agree to pay for attorney fees and other costs of collection in the event it becomes necessary to use attorney services to secure payment of the account.

_____ Signature

_____ Date