Christopher M. Rose, DDS • MS
ORTHODONTICS
Creating smiles for a lifetime

PATIENT INFORMATION

Name _____ _____ Date _____
FIRST LAST

Address _____
STREET ADDRESS

_____ _____ _____
CITY STATE ZIP

Email _____ Cell Number _____

Home Number _____ Birthdate _____

Age _____ Gender _____ ○ Male ○ Female

General Dentist _____ Approximate date of last visit _____

What concerns you most about your teeth? _____

Whom may we thank for your visit today? _____

Is there anyone else in your family that is interested in having a free consultation? _____

RESPONSIBLE PARTY INFORMATION

We do respect and protect your privacy.

Parent or Guardian Name _____ _____ Email _____
FIRST LAST

Address _____
STREET ADDRESS

_____ _____ _____
CITY STATE ZIP

How long at address? _____ Home Number _____

Work Phone _____ Cell Number _____

Social Security # _____ Birthdate _____

Relationship to Patient _____ Employer _____

Occupation _____ Number of years employed _____

Marital Status ○ Single ○ Married ○ Divorced ○ Other _____

Parent/Spouse's Name _____ Parent/Spouse's Employer _____

Occupation _____ Number of years employed _____

Social Security # _____ Birthdate _____

Cell Phone _____

DENTAL INSURANCE INFORMATION

If you have dental insurance, please provide the following information so that we can verify your benefits before your scheduled appointment.

Member's Name _____ _____
FIRST LAST

Date of Birth _____ Insurance Company _____

Member's Social Security # _____ Phone Number _____

Contract # _____ Group or local number _____

Do you have dual coverage? _____ ○ Yes ○ No

MEDICAL HISTORY

Physician _____

Date and reason for last visit _____

Is the patient allergic to latex? (rubber gloves) _____ ○ Yes ○ No

Please circle Yes or No (If yes, please fill in details) _____ ○ Yes ○ No

Are you taking medication? _____ ○ Yes ○ No

Are you allergic to any medication? _____ ○ Yes ○ No

Do you have a history of major illness? _____ ○ Yes ○ No

Do you have a history of cardiovascular illness? _____ ○ Yes ○ No

Have you ever been involved in a serious accident? _____ ○ Yes ○ No

Have there been any injuries to the face, mouth, or teeth? _____ ○ Yes ○ No

Are you presently in any dental pain? _____ ○ Yes ○ No

Is any part of your mouth sensitive to pressure or temperature? _____ ○ Yes ○ No

Do your gums bleed when you brush your teeth? _____ ○ Yes ○ No

Have you ever seen an Orthodontist? If yes, who and when? _____ ○ Yes ○ No

Do you experience jaw related headaches, clenching of teeth, or TMJ issues? _____ ○ Yes ○ No

Are there any medical conditions we have not discussed that you feel we should be aware of? _____ ○ Yes ○ No

BENEFITS

Benefits of Orthodontics: Aesthetics, Health and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. An informed consent form will be handed to the responsible party. Please read it carefully and let us answer any questions before the start of treatment. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history.

Signature of Parent/Guardian

Date _____