

### Patient Information Form

Patients Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Male/Female \_\_\_\_\_  
 Patient / Responsible Party (if patient is a child) E-mail address \_\_\_\_\_  
 Nick Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ S.S.# \_\_\_\_\_  
 Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
 Referred by \_\_\_\_\_ Dentist \_\_\_\_\_ Last Visit \_\_\_\_\_ Physician \_\_\_\_\_  
 Name of other family members treated here \_\_\_\_\_ Dr Lach Referred to \_\_\_\_\_

### Responsible Party Information

**Responsible Party Name** \_\_\_\_\_ S.S.# \_\_\_\_\_  
 Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
 Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_ Fax # \_\_\_\_\_ Pager # \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Marital Status \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Employer \_\_\_\_\_ Occupation \_\_\_\_\_ # Yrs. Emp. \_\_\_\_\_  
**Spouse's Name** \_\_\_\_\_ S.S.# \_\_\_\_\_  
 Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
 Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_ Fax # \_\_\_\_\_ Pager # \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Marital Status \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Employer \_\_\_\_\_ Occupation \_\_\_\_\_ # Yrs. Emp. \_\_\_\_\_

### Dental Insurance Information

Primary Insured Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_  
 Dental Insurance Co. \_\_\_\_\_ Phone # \_\_\_\_\_  
 Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
 Secondary Insured Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_  
 Dental Insurance Co. \_\_\_\_\_ Phone # \_\_\_\_\_  
 Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

### Medical and Dental History

Are you under the care of a physician at this time? \_\_\_\_\_  
 Is there any medication now being taken? \_\_\_\_\_ If so, please list \_\_\_\_\_  
 Are you allergic to any medication? \_\_\_\_\_ List \_\_\_\_\_  
 Do you have chronic difficulty breathing through your nose? \_\_\_\_\_  
 Have you ever had any baby teeth or permanent teeth removed by your dentist? \_\_\_\_\_  
 Any tooth grinding at night? \_\_\_\_\_  
 Do you bite your lip, nail or tongue or chew on pencils? \_\_\_\_\_  
 Do you suck any fingers, thumb or tongue now? \_\_\_\_\_  
 Do you like the way your teeth look? \_\_\_\_\_  
 Do you play any musical instrument that touches the lips? \_\_\_\_\_  
 Are you sensitive, quiet or outgoing? \_\_\_\_\_  
 What is your attitude toward receiving orthodontic treatment? \_\_\_\_\_  
 Have you ever seen an orthodontist? \_\_\_\_\_ When? \_\_\_\_\_  
 How many times a day do you brush your teeth? \_\_\_\_\_  
 Please circle any of the medical conditions that you have had or currently have.

Anemia	Epilepsy	Nervous Disorders	Tuberculosis
Arthritis	Heart Problems	Pneumonia	Tumor or Cancer
Asthma or Hayfever	Hepatitis	Prolonged Bleeding	Other/Explain _____
Bone Disorders	Herpes	Rheumatic Fever	_____
Diabetes	High Blood Pressure	Repeated Headaches	_____
Dizziness	Kidney or Liver Disease	Sexually Transmitted Disease	_____

Are there any medical conditions we have not discussed that you feel we should be aware of? Explain \_\_\_\_\_  
 Please record below what prompted you to seek an evaluation here, what your expectations are regarding treatment and anything else about yourself you would like us to be aware of. We ask these questions to facilitate offering you the best care possible. All information is regarding as confidential. Thank you for your cooperation.

Signed \_\_\_\_\_ Date \_\_\_\_\_