

*Welcome to Eckels Orthodontics!  
Thank you for choosing our orthodontic team.  
To aid us in better communication, please fill out this form completely.*



**Date:** \_\_\_\_\_

**Patient Information:**

Patient's Name: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_  
Patient's Address: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home # \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
Other family members seen by us: \_\_\_\_\_  
Dentist Name: \_\_\_\_\_ Date of Last Cleaning: \_\_\_\_\_  
Patient's E-mail Address: \_\_\_\_\_  
If Patient is school age: School Attended \_\_\_\_\_ Grade \_\_\_\_\_

**In the Event of an Emergency, Please Contact:**

Name: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Home # \_\_\_\_\_ Mobile/Pager # \_\_\_\_\_ Work # \_\_\_\_\_

**Responsible Party:**

Name: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Address: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
DOB \_\_\_\_\_ SSN \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
Home # \_\_\_\_\_ Mobile/Pager # \_\_\_\_\_ Work # \_\_\_\_\_  
E-mail Address: \_\_\_\_\_  
Employer Name: \_\_\_\_\_ City \_\_\_\_\_  
Spouse Name: \_\_\_\_\_ DOB \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Work # \_\_\_\_\_  
Is there a second responsible party on this account? If so, please list name, address, & phone information  
Name: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home # \_\_\_\_\_ Mobile/Pager # \_\_\_\_\_ Work # \_\_\_\_\_

**Primary Dental Insurance (Please provide insurance card for us to copy)**

Insurance Company: \_\_\_\_\_  
Address: \_\_\_\_\_  
Insurance Company Phone: \_\_\_\_\_ Group#: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
Name of Insured (as it appears on the card): \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_  
Employer Name: \_\_\_\_\_ City \_\_\_\_\_

**Secondary Dental Insurance (Please provide insurance card for us to copy)**

Insurance Company: \_\_\_\_\_  
Address: \_\_\_\_\_  
Insurance Company Phone: \_\_\_\_\_ Group#: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
Name of Insured (as it appears on the card): \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_  
Employer Name: \_\_\_\_\_ City \_\_\_\_\_

**MEDICAL HISTORY**

Do you have a personal physician? Yes \_\_\_\_\_ No \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Date of last visit: \_\_\_\_\_ Your current physical health is: Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

For Women: Are you pregnant? \_\_\_\_\_

List all medications that you are currently taking (prescription and non-prescription)

**Have you ever had any of the following diseases or medical problems?**

- |                             |                                   |                              |
|-----------------------------|-----------------------------------|------------------------------|
| Y N Abnormal Bleeding       | Y N Hemophilia                    | Y N Anemia                   |
| Y N Hepatitis               | Y N High / Low Blood Pressure     | Y N Asthma / Arthritis       |
| Y N HIV+ / AIDS             | Y N Cancer / Chemotherapy         | Y N Radiation Treatments     |
| Y N Diabetes                | Y N Psychiatric Problems          | Y N Difficulty Breathing     |
| Y N Drug / Alcohol Abuse    | Y N Epilepsy /Seizures / Fainting | Y N Sinus Problems           |
| Y N Heart Attack / Stroke   | Y N Heart Murmur                  | Y N Congenital Heart Defect  |
| Y N Fever Blisters / Herpes | Y N TMJ Discomfort                | Y N Severe / Freq. Headaches |

Please list any serious medical condition(s) that you have ever had:

List any drugs and/or materials that you are allergic to:

**Habits:**

Y N Thumb or Finger Sucking, How Long? \_\_\_\_\_

Y N Speech Problems Y N Mouth Breathing

Y N Nail Biting Y N Grinding Teeth

**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 \_\_\_\_\_

If yes, when? \_\_\_\_\_

Has either parent had orthodontic treatment? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you like your smile? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you play a musical instrument? Yes \_\_\_\_\_ No \_\_\_\_\_ What instrument? \_\_\_\_\_

Current dental health is: Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_ Gums ever bleed? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ /TMD)? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever had an injury to your? Face Mouth Teeth Chin (please circle)

Do you have any speech problems: Yes \_\_\_\_\_ No \_\_\_\_\_ Please list: \_\_\_\_\_

Do you generally breathe through your mouth? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please circle: While awake? While asleep?

Do you have any missing or extra permanent teeth? Yes \_\_\_\_\_ No \_\_\_\_\_

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. I also understand that I am responsible for any unpaid balance not covered by my insurance carrier.

Signature & Date