

Patient's Name		Child Pation	ent Informat	ion	
Mailing Address	Patient's Name				
Birth Date					
Date of Last Dental Check Up Whom may we thank for referring you to our office? Email address: State Single Married Divorced Separated					
Responsible Party Information Single Married Divorced Separated Address State Zip Yrs State Tip Yrs Social Security Number Social Security Number Occupation Vears Employed Divorced Separated Divorced Divo					
Responsible Party Information					
Responsible Party Information Father's Name					
Father's Name					
Father's Name		Responsible	Party Inform	nation	
Address					
Address City State Zip Yrs	Father's Name				Divorced Separated
Social Security Number Birth Date Relationship to Patient				State Zip	Yrs
Social Security Number Birth Date					
Mother's Name	Social Security Number	Birth Date/	/R	Relationship to Patient	
Address City State Zip Yrs Home Phone Work Phone Cell Phone Social Security Number - Birth Date / Relationship to Patient Employer Occupation Years Employed Nocupation SSN	Employer	Occupation		Yea	rs Employed
Address City State Zip Yrs Home Phone Work Phone Cell Phone Social Security Number - Birth Date / Relationship to Patient Employer Occupation Years Employed Nocupation SSN					
Home Phone Work Phone Cell Phone Social Security Number Birth Date / Relationship to Patient	Mother's Name	A		□Single □Married □D	ivorced □Separated
Social Security Number	Address	City		State Zip	Yrs
Insurance Information Policy Holder's Name	Home Phone	Work Phone		Cell Phone	
Insurance Information SSN Insurance Company ID No. Group No. Insurance Co Address City State Zip Insurance Company ID No. Group No. Insurance Co Address City State Zip Insurance Co Address City State Zip Insurance Co Address City State Zip Insurance Company ID No. Group No. Insurance Co Address City State Zip Insurance Company ID No. City State Zip Insurance Company Insurance Co	Social Security Number	Birth Date/	/R	Relationship to Patient	
Policy Holder's Name	Employer	Occupation	1	Years Employed	
Policy Holder's Name					
Insurance Company		<u>Insuranc</u>	e Informatio	<u>on</u>	
Insurance Company					
Insurance Co Address City State Zip Phone Birth Date / SSN	Policy Holder's Name	Birt	n Date/	'/ SSN	
Phone	Insurance Company		ID No	Group No)
Birth Date	Insurance Co Address		City	State	Zip
Insurance Company ID No Group No Insurance Co Address City State Zip Phone Please Note: We call to check on orthodontic benefits as a courtesy to our patients, this is not a guarantee of benefits. If you wish to proceed with orthodontic treatment we will gladly work with your insurance company.	Phone			alastic	
Phone Please Note: We call to check on orthodontic benefits as a courtesy to our patients, this is not a guarantee of benefits. If you wish to proceed with orthodontic treatment we will gladly work with your insurance company.	2 nd Insured's Name	Birt	h Date/	// SSN	
Please Note: We call to check on orthodontic benefits as a courtesy to our patients, this is not a guarantee of benefits. If you wish to proceed with orthodontic treatment we will gladly work with your insurance company.	Insurance Company		ID No	Group No)
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Fundamental Company Linforms at the Company of the				•	
For a way of Comback Information					
Emergency Contact Information		Fmergency Co	ontact Inform	mation	

Name of nearest relative not living with you:_

Phone:

Are you interested in: (Please indicate all that apply) Information Treatment now Clarification of previous or conflicting information
Information Treatment now Clarification of previous or conflicting information
1. Have there been injuries to the face, mouth, or teeth?
2. Does the patient have any speech problems? 3. Has the patient ever been informed of any missing or extra permanent teeth? 4. Has any previous orthodontic treatment been rendered? 5. Does the patient suffer from any jaw joint problems such as pain, clicking, popping, etc.? 6. Have you ever observed your child has any habits? Thumb/finger sucking Mouth breathing Tongue thrust Name of your physician
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4. Has any previous orthodontic treatment been rendered?
5. Does the patient suffer from any jaw joint problems such as pain, clicking, popping, etc.?
Medical History Name of your physician
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Name of your physician
Name of your physician
1. Is the patient in good health?
1. Is the patient in good health?
2. Does the patient have a health problem?
3. Does the patient have allergies to medications, medical products (latex) or, to the environment (dust mites, pollen, etc,)? Yes
□Yes □No If yes, please list: 4. Please list any current prescription medications: 5. Has the patient had any recent rapid growth □Yes □No □No If yes, when? Pregnant? □Yes □No 6. Has the patient been treated by a physician for any of the following conditions? (Check any that apply) □ Problems at Birth □ Hepatitis/Liver Disease □ Seizures □ Heart Disease/Murmur □ Tuberculosis □ Cleft Lip/Palate □ Rheumatic Fever □ Kidney Disease □ Speech or Hearing Problems □ Sickle Cell Anemia □ Cancer/Radiation Therapy □ Tonsil, Adenoid, Sinus Problems □ Anemia/Hemophilia □ Cerebral Palsy □ Emotional/Behavior Problems □ Diabetes □ Arthritis □ Learning Disabilities
4. Please list any current prescription medications: 5. Has the patient had any recent rapid growth Yes No Early? Late? Females: Has menstruation begun? Yes No If yes, when? Pregnant? Yes No No Pregnant? Yes No No No No No No No N
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If yes, when? Pregnant?
6. Has the patient been treated by a physician for any of the following conditions? (Check any that apply) Problems at Birth
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□ Heart Disease/Murmur □ Tuberculosis □ Cleft Lip/Palate □ Rheumatic Fever □ Kidney Disease □ Speech or Hearing Problems □ Sickle Cell Anemia □ Cancer/Radiation Therapy □ Tonsil, Adenoid, Sinus Problems □ Anemia/Hemophilia □ Cerebral Palsy □ Emotional/Behavior Problems □ Diabetes □ Arthritis □ Learning Disabilities
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□ Sickle Cell Anemia □ Cancer/Radiation Therapy □ Tonsil, Adenoid, Sinus Problems □ Anemia/Hemophilia □ Cerebral Palsy □ Emotional/Behavior Problems □ Diabetes □ Arthritis □ Learning Disabilities
□ Anemia/Hemophilia □ Cerebral Palsy □ Emotional/Behavior Problems □ Diabetes □ Arthritis □ Learning Disabilities
□ Diabetes □ Arthritis □ Learning Disabilities
2 State Co.
AIDS or HIV
Other:
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I understand that the information I have given is correct to the best of my knowledge, and that it is my
responsibility to inform this office of any changes. This office reserves the right to verify the credit status of
potential patients and/or parents of patients prior to extending credit for treatment fees.
Responsible party signature Date

MICHAEL L. GEORGE, D.D.S., M.S.D., P.S.

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