VLACHOS
ORTHODONTICS
3045 Independence Dr., Homewood, AL 35209
www.vlachosorthodontics.com • 205–871–5557

PATIENT INFORMATION

Patient's Legal Name: _____ DOB: _____ Sex: _____
First Middle Last
Home Address: _____
Street City State Zip
Home Phone: _____ Cell Phone: _____ Business Phone:_____
Primary Email Address: _____ Referred by: _____
School: _____ Grade: _____
General Dentist: _____ Family Physician: _____
Name Phone Name Phone

RESPONSIBLE PARTY INFORMATION

Mother's Name: _____ Home Phone: _____ DOB: _____
Home Address: _____
Street City State Zip
Email: _____ Social Security Number: _____
Home Phone: _____ Cell Phone: _____ Business Phone:_____
Employer: _____ Occupation: _____ Business Phone: _____

Father's Name: _____ Home Phone: _____ Cell: _____
Home Address: _____
Street City State Zip
Email Address: _____ Social Security Number: _____
Home Phone: _____ Cell Phone: _____ Business Phone:_____
Employer: _____ Occupation: _____ Business Phone: _____

Patient Resides with: _____ Siblings(Name/Age) _____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship to Patient: _____ Phone: _____
Name _____ Relationship to Patient: _____ Phone: _____

PRIMARY DENTAL INSURANCE

Subscriber's Name: _____
DOB: _____ Relationship to Patient:_____
SSN: _____
Contract Number: _____
Group Number: _____
Subscriber's Employer: _____

Company: _____
Phone Number: _____
Insurance Address: _____

SECONDARY DENTAL INSURANCE

Subscriber's Name: _____
DOB: _____ Relationship to Patient:_____
SSN: _____
Contract Number: _____
Group Number: _____
Subscriber's Employer: _____

Company: _____
Phone Number: _____
Insurance Address: _____

Does the patient have any allergies to latex, penicillin, nickel etc. _____
Has the patient received any medical treatment from a n allergist or ear, nose and throat specialist? _____
If so, when _____ Physician _____
Has the patient had any unusual dental experiences? _____
If yes, please specify _____
Date of last dental checkup: _____ Were the patient's teeth cleaned? YES NO
Has the patient ever been treated for TMJ? YES NO If so, what treatment has be done ?_____
_____ Physician? _____
Please list any current medications: _____
_____

	NO	YES
Is the patient currently taking any Biophosphonates?		
Does the patient breathe through the mouth?		
Snore when sleeping?		
Have frequent colds?		
Have a frequent "stuffy nose"?		
Have frequent sore throats or tonsillitis?		
Have chewing or swallowing difficulty?		
Have difficulty in opening mouth?		
Have pain or clicking in jaw joint?		
Have pain in or about the ears or cheeks?		
Have a bite that feels "uncomfortable or "unusual"?		
Have a jaw that "locks", "gets stuck" or "goes out"?		
Does the patient experience any clenching or grinding of teeth?		
Have tongue thrusting or other functional problems?		
Does the patient need to be "pre-medicated" with antibiotics before dental treatment?		
How many times a day does the patient brush and floss?		
Has the patient previously had an orthodontic consult?		
Has the patient had previous orthodontic treatment?		

PLEASE CHECK ALL THAT APPLY:

	YES	NO		YES	NO
Anemia			Diabetes		
Arthritis			Endocrine Problems		
Asthma			Headaches		
Autoimmune Problems			High Blood Pressure		
Bone Disorders			Hepatitis		
Cancer			HIV		
Chicken Pox			Fever Blisters		
Chronic Neck Pain			Nervous Disorder		
Congenital Heart Condition			Muscular Disorders		
Kidney Disease			Epilepsy		
Mononucleosis			Organ Transplant		
Periodontal Disorder			Autism		