

Thank you for providing this important information to help us serve you best. If you have any questions or need assistance, just ask. We're happy to help!



**GARDENDALE 909 MOUNT OLIVE RD. | GARDENDALE, AL 35071 · (205) 631-6033**  
**ALABASTER 100 SOUTH COLONIAL DR. SUITE 800 | ALABASTER, AL 35007 · (205) 621-1111**

### Patient Information

NAME \_\_\_\_\_ PREFERRED NAME \_\_\_\_\_ GENDER \_\_\_\_\_  
BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ GRADE \_\_\_\_\_ SCHOOL ATTENDS \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
NAME/RELATIONSHIP OF PERSON ACCOMPANYING PATIENT TO TODAY'S APPOINTMENT \_\_\_\_\_  
WHO HAS LEGAL CUSTODY OF PATIENT? \_\_\_\_\_  
NAME OF SIBLINGS & AGES \_\_\_\_\_  
HAVE WE TREATED ANY FAMILY MEMBERS? IF YES, WHO? \_\_\_\_\_  
WHOM MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_

### Responsible Party

MARRIED  DOMESTIC PARTNERSHIP  SEPARATED  DIVORCED  WIDOWED  SINGLE

PARENT/GUARDIAN NAME _____	PARENT/GUARDIAN NAME _____
RELATIONSHIP TO PATIENT _____	RELATIONSHIP TO PATIENT _____
DATE OF BIRTH _____	DATE OF BIRTH _____
ADDRESS _____	ADDRESS _____
CITY _____ STATE _____ ZIP _____	CITY _____ STATE _____ ZIP _____
HOW LONG AT THIS ADDRESS? _____	HOW LONG AT THIS ADDRESS? _____
CELL PHONE _____	CELL PHONE _____
WORK PHONE _____	WORK PHONE _____
EMPLOYER _____ YEARS EMPLOYED _____	EMPLOYER _____ YEARS EMPLOYED _____
OCCUPATION _____	OCCUPATION _____
EMAIL _____	EMAIL _____

### Primary Insurance Information

CHECK HERE IF NO ORTHODONTIC COVERAGE WILL BE APPLIED

INSURANCE COMPANY _____	INSURANCE PHONE NUMBER _____
EMPLOYER/GROUP NAME _____	GROUP NUMBER _____
SUBSCRIBER/EMPLOYEE _____	SUBSCRIBER ID/SSN _____
DATE OF BIRTH _____	RELATIONSHIP TO PATIENT _____

### Secondary Insurance Information

CHECK HERE IF NO SECONDARY INSURANCE

INSURANCE COMPANY _____	INSURANCE PHONE NUMBER _____
EMPLOYER/GROUP NAME _____	GROUP NUMBER _____
SUBSCRIBER/EMPLOYEE _____	SUBSCRIBER ID/SSN _____
DATE OF BIRTH _____	RELATIONSHIP TO PATIENT _____

### Emergency Contact Information (OTHER THAN RESPONSIBLE PARTY)

NAME \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

Please take a moment to complete the reverse side of this form.

PLEASE READ: We are passionate about our mission to give everyone a great smile. Please help us help you and your child by letting us know of any delayed development, social disabilities, ADD or ADHD, Bipolar, Autism, etc. \_\_\_\_\_

## Medical History

PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_ DATE OF LAST EXAM \_\_\_\_\_

<p>1. IS THE PATIENT UNDER MEDICAL TREATMENT NOW? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>2. HAS THE PATIENT BEEN HOSPITALIZED FOR ANY SURGICAL OPERATIONS OR SERIOUS ILLNESS IN THE PAST FIVE YEARS? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>3. IS THE PATIENT TAKING MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE? <input type="checkbox"/> Y <input type="checkbox"/> N IF YES, WHAT MEDICATION(S)? _____</p> <p>4. DOES THE PATIENT USE TOBACCO? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>5. IS THE PATIENT ALLERGIC TO ANY MEDICATIONS OR SUBSTANCE, INCLUDING METALS? <input type="checkbox"/> Y <input type="checkbox"/> N IF YES, WHAT? _____</p> <p>6. FEMALES ONLY: A. HAS MENSTRUATION BEGUN? IF YES, DATE: _____ <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>B. IS THE PATIENT PREGNANT, OR THINK THEY MAY BE? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>7. HAS THE PATIENT REACHED PUBERTY? <input type="checkbox"/> Y <input type="checkbox"/> N</p>	<p>8. HAS THE PATIENT EVER BEEN EVALUATED FOR AIRWAY OBSTRUCTION AND/OR SLEEP APNEA? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>9. EVER TAKEN BISPHOSPHONATES (EX: FOSAMAX) FOR OSTEOPOROSIS? <input type="checkbox"/> Y <input type="checkbox"/> N IF YES, SPECIFY _____</p> <p>10. PLEASE CHECK ALL THAT APPLY:</p> <table border="0"> <tr> <td><input type="checkbox"/> HAY FEVER/ALLERGIES</td> <td><input type="checkbox"/> LEUKEMIA</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> COLD SORES</td> <td><input type="checkbox"/> KIDNEY/LIVER DISEASE</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> MIGRAINES</td> <td><input type="checkbox"/> ANEMIA</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> DIABETES/GLAUCOMA</td> <td><input type="checkbox"/> CANCER</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> RHEUMATIC FEVER</td> <td><input type="checkbox"/> JOINT REPLACEMENT/IMPLANT</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> AIDS OR HIV INFECTION</td> <td><input type="checkbox"/> HEPATITIS/JAUNDICE</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> CARDIAC PACEMAKER</td> <td><input type="checkbox"/> STOMACH TROUBLES/ULCERS</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> ASTHMA (INHALER)</td> <td><input type="checkbox"/> SINUS PROBLEMS</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> FAINTING/SEIZURES</td> <td><input type="checkbox"/> STROKE</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> THYROID PROBLEM</td> <td><input type="checkbox"/> RADIATION THERAPY</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> HIGH/LOW BLOOD PRESSURE</td> <td><input type="checkbox"/> RESPIRATORY PROBLEMS</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> HEART TROUBLE</td> <td><input type="checkbox"/> BONE DISORDER</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> EPILEPSY/CONVULSIONS</td> <td><input type="checkbox"/> OSTEOPEMIA/OSTEOPOROSIS</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> TAKING MEDICATION:</td> <td><input type="checkbox"/> REMOVAL OF ADENOIDS/TONSILS</td> <td><input type="checkbox"/></td> </tr> </table> <p>IF SO, SPECIFY: _____</p>	<input type="checkbox"/> HAY FEVER/ALLERGIES	<input type="checkbox"/> LEUKEMIA	<input type="checkbox"/>	<input type="checkbox"/> COLD SORES	<input type="checkbox"/> KIDNEY/LIVER DISEASE	<input type="checkbox"/>	<input type="checkbox"/> MIGRAINES	<input type="checkbox"/> ANEMIA	<input type="checkbox"/>	<input type="checkbox"/> DIABETES/GLAUCOMA	<input type="checkbox"/> CANCER	<input type="checkbox"/>	<input type="checkbox"/> RHEUMATIC FEVER	<input type="checkbox"/> JOINT REPLACEMENT/IMPLANT	<input type="checkbox"/>	<input type="checkbox"/> AIDS OR HIV INFECTION	<input type="checkbox"/> HEPATITIS/JAUNDICE	<input type="checkbox"/>	<input type="checkbox"/> CARDIAC PACEMAKER	<input type="checkbox"/> STOMACH TROUBLES/ULCERS	<input type="checkbox"/>	<input type="checkbox"/> ASTHMA (INHALER)	<input type="checkbox"/> SINUS PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/> FAINTING/SEIZURES	<input type="checkbox"/> STROKE	<input type="checkbox"/>	<input type="checkbox"/> THYROID PROBLEM	<input type="checkbox"/> RADIATION THERAPY	<input type="checkbox"/>	<input type="checkbox"/> HIGH/LOW BLOOD PRESSURE	<input type="checkbox"/> RESPIRATORY PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/> HEART TROUBLE	<input type="checkbox"/> BONE DISORDER	<input type="checkbox"/>	<input type="checkbox"/> EPILEPSY/CONVULSIONS	<input type="checkbox"/> OSTEOPEMIA/OSTEOPOROSIS	<input type="checkbox"/>	<input type="checkbox"/> TAKING MEDICATION:	<input type="checkbox"/> REMOVAL OF ADENOIDS/TONSILS	<input type="checkbox"/>
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## Dental History

DENTIST \_\_\_\_\_

DATE OF LAST CLEANING \_\_\_\_\_

<p>1. IS THE PATIENT ANXIOUS OR NERVOUS ABOUT DENTAL TREATMENT? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>2. DOES THE PATIENT REQUIRE PREMEDICATION FOR DENTAL TREATMENT? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>3. DOES THE PATIENT FEEL PAIN TO ANY OF THEIR TEETH? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>4. DOES THE PATIENT HAVE SORES OR LUMPS IN OR NEAR MOUTH? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>5. HAS THE PATIENT HAD ANY HEAD, NECK, OR JAW INJURIES? <input type="checkbox"/> Y <input type="checkbox"/> N IF YES, PLEASE DESCRIBE: _____</p> <p>6. DOES THE PATIENT HAVE ANY ONGOING JAW PROBLEMS WITH:</p> <table border="0"> <tr> <td>A. CHRONIC CLICKING OR POPPING?</td> <td><input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> <tr> <td>B. PAIN?</td> <td><input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> <tr> <td>C. DIFFICULTY OPENING OR CLOSING?</td> <td><input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> <tr> <td>D. DIFFICULTY IN CHEWING?</td> <td><input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> </table> <p>7. DOES THE PATIENT CLENCH OR GRIND THEIR TEETH? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>8. DOES THE PATIENT BITE THEIR LIPS OR CHEEKS FREQUENTLY? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>9. HAS THE PATIENT EVER HAD SPEECH THERAPY? <input type="checkbox"/> Y <input type="checkbox"/> N IF YES, PLEASE DESCRIBE: _____</p>	A. CHRONIC CLICKING OR POPPING?	<input type="checkbox"/> Y <input type="checkbox"/> N	B. PAIN?	<input type="checkbox"/> Y <input type="checkbox"/> N	C. DIFFICULTY OPENING OR CLOSING?	<input type="checkbox"/> Y <input type="checkbox"/> N	D. DIFFICULTY IN CHEWING?	<input type="checkbox"/> Y <input type="checkbox"/> N	<p>11. IS THERE ANY OUTSTANDING DENTAL TREATMENT TO BE COMPLETED? <input type="checkbox"/> Y <input type="checkbox"/> N IF YES, PLEASE DESCRIBE: _____</p> <p>12. HAS THE PATIENT EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING AND FLOSSING YOUR TEETH? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>13. DOES THE PATIENT HAVE ANY OF THE FOLLOWING ORAL HABITS:</p> <table border="0"> <tr> <td>A. NAIL BITING?</td> <td><input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> <tr> <td>B. THUMB SUCKING?</td> <td><input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> <tr> <td>C. TONGUE THRUST WHILE SWALLOWING?</td> <td><input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> <tr> <td>D. MOUTH BREATHING?</td> <td><input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> </table> <p>14. HOW MANY TIMES A DAY DOES THE PATIENT BRUSH? _____</p> <p>15. PLEASE CHECK THE BOXES BELOW WHICH DESCRIBE THE PROBLEM(S) FOR WHICH THE PATIENT IS SEEKING TREATMENT:</p> <table border="0"> <tr> <td><input type="checkbox"/> CROWDING</td> <td><input type="checkbox"/> MISSING TEETH</td> </tr> <tr> <td><input type="checkbox"/> EXTRA SPACE</td> <td><input type="checkbox"/> EXTRA PERMANENT TEETH</td> </tr> <tr> <td><input type="checkbox"/> TEETH STICK OUT TOO FAR</td> <td><input type="checkbox"/> TEETH ERUPTING IN THE WRONG POSITION</td> </tr> <tr> <td><input type="checkbox"/> TMJ PROBLEMS</td> <td><input type="checkbox"/> OTHER: _____</td> </tr> <tr> <td><input type="checkbox"/> POOR BITE RELATIONSHIP</td> <td></td> </tr> </table> <p>16. HAS THE PATIENT HAD AN ORTHODONTIC EVALUATION OR TREATMENT BEFORE? <input type="checkbox"/> Y <input type="checkbox"/> N IF SO, WHEN AND BY WHOM? _____</p>	A. NAIL BITING?	<input type="checkbox"/> Y <input type="checkbox"/> N	B. THUMB SUCKING?	<input type="checkbox"/> Y <input type="checkbox"/> N	C. TONGUE THRUST WHILE SWALLOWING?	<input type="checkbox"/> Y <input type="checkbox"/> N	D. MOUTH BREATHING?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> CROWDING	<input type="checkbox"/> MISSING TEETH	<input type="checkbox"/> EXTRA SPACE	<input type="checkbox"/> EXTRA PERMANENT TEETH	<input type="checkbox"/> TEETH STICK OUT TOO FAR	<input type="checkbox"/> TEETH ERUPTING IN THE WRONG POSITION	<input type="checkbox"/> TMJ PROBLEMS	<input type="checkbox"/> OTHER: _____	<input type="checkbox"/> POOR BITE RELATIONSHIP	
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## Authorization and Release

TO THE BEST OF MY KNOWLEDGE THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES TO THE PATIENT'S MEDICAL STATUS. I GIVE CANALES ORTHODONTICS PERMISSION TO PERFORM AN ORTHODONTIC EXAMINATION AND EVALUATION.

SIGNATURE OF PATIENT (OR PARENT IF MINOR) \_\_\_\_\_ DATE \_\_\_\_\_

PRINT NAME \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

Please list who we can share information with: \_\_\_\_\_