LAKE COUNTRY ORTHODONTICS
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Patient Information

Patient Name: _____ **Sex:** [ ]M - [ ]F

D.O.B: _____/_____/_____ **Social Security Number:** _____/_____/_____

Address/City/St/Zip: _____

Home #: _____**Cell Phone #:** _____**Work #:** _____

Responsible Party Information

Responsible Billing Party: _____ **Relationship:** _____

Address/City/St/Zip: _____

Home #: _____**Cell Phone #:** _____**Work #:** _____

D.O.B: ____/____/____ **Social Security Number:** _____/_____/_____ **Email:** _____

Employer: _____ **Insurance Company:** _____

Phone #: _____ **Plan Name/Plan #:** _____ **Group #:** _____

Other Responsible Party: _____ **Relationship:** _____

Address/City/St/Zip: _____

Home #: _____**Cell Phone #:** _____**Work #:** _____

D.O.B: ____/____/____ **Social Security Number:** _____/_____/_____ **Email:** _____

Employer: _____ **Insurance Company:** _____

Phone #: _____ **Plan Name/Plan #:** _____ **Group #:** _____

Dental History

Dentist Name: _____

Address/City/St/Zip: _____

Date of Last Visit: _____ **Reason for Visit:** _____

Any Missing Teeth: _____ **How Often Does Patient Brush:** _____ **Floss:** _____

Referral Source: _____

Dental History

What Is Your Primary Concern: _____

Does Patient Have A History of Any of The Following – If YES Please Explain:

[ ]YES [ ]NO **Thumb Sucking Habit** [ ]YES [ ]NO **Periodontal "gum problems"** [ ]YES [ ]NO **Popping Jaw**
[ ]YES [ ]NO **Jaw Fractures** [ ]YES [ ]NO **Sensitive Teeth** [ ]YES [ ]NO **Bleeding Gums**
Other: _____

Medical History

Patient Physician's Name: _____ **Phone#**_____

If YES, Please Explain:

[ ]YES [ ]NO **Is Patient Under the Care of A Physician:** _____
[ ]YES [ ]NO **Is Patient Taking Any Medication:** _____
[ ]YES [ ]NO **Does Patient Have Any Known Allergies:** _____

Does Patient Have A History of The Any of The Following – If YES Please Explain:

[ ]YES [ ]NO **AIDS**	[ ]YES [ ]NO **Drug/Alcohol Addiction**	[ ]YES [ ]NO **Measles**
[ ]YES [ ]NO **Anemia**	[ ]YES [ ]NO **Epilepsy**	[ ]YES [ ]NO **Mononucleosis**
[ ]YES [ ]NO **Asthma**	[ ]YES [ ]NO **Fainting**	[ ]YES [ ]NO **Mumps**
[ ]YES [ ]NO **Bladder Problems**	[ ]YES [ ]NO **Hearing Problems**	[ ]YES [ ]NO **Rheumatic Fever**
[ ]YES [ ]NO **Cancer**	[ ]YES [ ]NO **Heart Problems**	[ ]YES [ ]NO **Sinus Problems**
[ ]YES [ ]NO **Cerebral Palsy**	[ ]YES [ ]NO **Hepatitis**	[ ]YES [ ]NO **Thyroid Problems**
[ ]YES [ ]NO **Chicken Pox**	[ ]YES [ ]NO **High/Low Blood Pressure**	[ ]YES [ ]NO **Tuberculosis**
[ ]YES [ ]NO **Convulsions**	[ ]YES [ ]NO **Kidney Problems**	[ ]YES [ ]NO **Ulcers**
[ ]YES [ ]NO **Diabetes**	[ ]YES [ ]NO **Liver Problems**	**OTHER:** _____

I authorize Dr. Cabal, Lake Country Orthodontics or any member if his responsible staff to disclose any of the information I have included on this form to any outside health care provider that I/patient stated above am/is referred to.

I have read and understand the above questions. I will not hold Dr. Cabal, Lake Country Orthodontics or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this health history record or medical/dental status, I understand that it is my responsibility to inform the Dr. Cabal or the staff of Lake Country Orthodontics.

_____ _____
Patient/Parent Signature ***Date Signed***

_____ _____
Staff Signature ***Date Signed***

_____ _____
Doctor's Signature ***Date Signed***

Doctor's Comments: _____

_____