Darcy C. Cruikshank DMD, MSD, LLC
Lauren M. Weber DDS, MS, PC
SPECIALISTS IN ORTHODONTICS

*Today's Date*_____

Patient's First Name	Middle Initial	Last Name	Nickname	Date of Birth	Age	Gender

Patient's Dentist	Referred By	Patient's School & Grade

Orthodontic Insurance Carrier	Insurance Phone Number	Medical Savings Plan?

Who is accompanying the patient today?_____ Relationship to patient?_____

With whom does the patient live?_____ Who receives treatment information?_____

Who is financially responsible for this account?_____ Adopted?_____

Parent's marital status? Married____ Separated____ Divorced____ Domestic Partnership____ Widow(er)____ Remarried____ Single____

Patient's Parent (Mother/Father)

First Name_____
Last Name_____
Social Security #_____
Date of Birth_____ Gender_____
Address_____
City/State/Zip_____
Home Phone_____
Cell Phone_____
E-mail_____
Occupation_____
Employer_____
City/State_____
Work Phone_____

Patient's Parent (Mother/Father)

First Name_____
Last Name_____
Social Security #_____
Date of Birth_____ Gender_____
Address_____
City/State/Zip_____
Home Phone_____
Cell Phone_____
E-mail_____
Occupation_____
Employer_____
City/State_____
Work Phone_____

PRIMARY DENTAL INSURANCE COMPANY

Insured Party_____
Relationship to patient_____
Employer_____
Bus. Address_____
Date of Birth_____ SS#_____
Ins. Co. Name_____
Address_____
Group #_____ Group Name_____
Subscriber I.D. #_____

SECONDARY DENTAL INSURANCE COMPANY

Insured Party_____
Relationship to patient_____
Employer_____
Bus. Address_____
Date of Birth_____ SS#_____
Ins. Co. Name_____
Address_____
Group #_____ Group Name_____
Subscriber I.D. #_____

Any other adults responsible for care?_____

Relationship to patient_____ Relationship to patient_____

Last Name_____ Last Name_____

First Name_____ First Name_____

Address_____ Address_____

Phone_____ Phone_____

Primary concern with teeth:_____

_____

_____

Has the patient been under the care of a physician during the past two years?_____

Physician's name_____City_____

Is the patient taking any medication or drugs?_____

Does the patient have a history of major illness or hospital stay?_____

Please check the following that the patient has been diagnosed with:

- ☐ Allergies (seasonal)
- ☐ Allergies (metal)
- ☐ Allergies (latex)
- ☐ Allergies (medication)
- ☐ Asthma
- ☐ Congenital Defects
- ☐ Behavorial/Learning problems
- ☐ Diabetes (Type:_____)
- ☐ Epilepsy
- ☐ Headaches (Frequency_____)
- ☐ Heart Murmur
- ☐ HIV/Aids
- ☐ Injury to face/jaw (Please explain below)
- ☐ Rheumatic Fever
- ☐ Psychiatric Illness (examples: depression, bipolar, anxiety)
- ☐ Tuberculosis

Describe other medical concerns:_____

Special needs:_____

Have tonsils and adenoids been removed? If yes, what age?_____

Has the patient ever sucked a thumb or fingers? If yes, until what age?_____

Has the patient or other family members had any previous orthodontic treatment?_____

Has the patient been informed of any missing or extra permanent teeth?_____

Does the patient have any jaw pain or noise in the jaw joint?_____

Does the patient play a musical instrument (mouth only)? If yes, hours /day_____

Girls only: Have menstrual periods started? If yes, at what age?_____

Is there a possibility of pregnancy? Expected delivery date_____

Boys only: Voice change? Facial Hair? If yes, at what age?_____

Patient's Siblings

Name Date of Birth

_____

_____

_____

May we thank someone for referring you to our office?_____

Signature Today's date_____