Fred W. Carpenter, D.D.S.
Practice Limited to Orthodontics

Patient Information

Today's Date_____

Name_____ DateBirth_____ Age_____

Nickname_____ Hobbies_____ Male ☐ Female ☐

Patient's Dentist_____ Referred by_____

School_____ Grade in School_____

Residence Address_____

City_____ State_____ Zip_____

Residence Phone_____ Cell Phone_____

Parent Information

Marital Status: (Circle) Single Married Separated Divorced Widowed

Other Children in Family (Ages)_____

Father's Name_____	Mother's Name_____
Occupation_____	Occupation_____
Employer_____	Employer_____
Business_____	Business_____
Address_____	Address_____
Business Phone_____	Business Phone_____
Birthdate (for insurance)_____	Birthdate (for insurance)_____
Social Security#_____	Social Security #_____

Dental History

Reason for Orthodontic Visit?_____

Has Patient Seen Another Orthodontist?_____ Name_____

Date of Last Dental Check-up_____

Other Medical Information

a) Clicking of the Jaw Joint? Yes_____ No_____

b) Jaw Joint Pain? Yes_____ No_____

c) Jaw Joint Locking? Yes_____ No_____

Explain any yes answer_____

_____

Person Responsible for the Account (Please Check One)

Father_____ Mother_____ Someone Else_____

(If someone else is responsible for this account, please give appropriate information)

Name_____

Address_____

City_____ State_____ Zip_____

Relation to Patient_____

Do you have insurance coverage which includes orthodontic treatment for the members of your family? Yes ☐ No ☐

Insurance Company #1_____ Contract #_____

Insurance Company #2_____ Contract #_____

Credit Assistance

All patients wishing to pay orthodontic fees with an installment payment plan require credit verification by the local credit bureau. Unfavorable credit ratings require prepayment of fees. Favorable credit ratings may arrange appropriate installment payments.

PLEASE CHECK APPROPRIATE BOX:

☐ I do not wish credit and will prepay all fees.

☐ I wish credit for participation on installment payment plans and you have permission to verify my credit rating. I understand that the treatment will not be denied upon my credit rating, but that the methods available for payment of fees will be governed by the credit rating.

_____ Date_____

Signature of Responsible Person

Medical History

Because many medical conditions have an impact on dental treatment, it is important to have a comprehensive medical history to identify these conditions. Joint replacements, heart valve irregularities, high blood pressure and diabetes are just a few that may require special attention. We have always maintained a health history, but have recently changed it to a separate form. As a time saver, we are asking you to complete this today and at subsequent visits we can quickly update changes. Thank you for your cooperation!

Patient Name_____ Birthdate_____
Name of medical doctor_____ Phone_____
Address_____
Whom may we notify in case of an emergency Name_____ Phone_____
Relationship to you_____

Circle a definite answer for each question:

Yes No Are you currently under the care of a medical doctor?
If yes, describe your treatment_____
Yes No Have you had any medical treatment in the last two years?
If yes, describe_____
Yes No Have you had any surgery? When?
If yes, describe_____

Do you have, have you had, or been treated for any of the following?:

Yes	No	Heart Murmur	Yes	No	Radiation, Chemical Therapy
Yes	No	Mitral Valve Prolapse	Yes	No	Epilepsy, Seizures
Yes	No	Do you have a pacemaker	Yes	No	Fainting spells
Yes	No	Any other Heart problems	Yes	No	Ulcers
Yes	No	High Blood Pressure	Yes	No	Tuberculosis
Yes	No	Low Blood Pressure	Yes	No	Organ Transplants
Yes	No	Circulation Problems	Yes	No	Joint Replacement
Yes	No	Hemophilia	Yes	No	Kidney Disease
Yes	No	Anemia	Yes	No	Chemical dependency
Yes	No	Cold Sores	Yes	No	Anorexia, Bulimia
Yes	No	Shingles	Yes	No	HIV or AIDS related complex
Yes	No	Venereal Disease	Yes	No	Thyroid condition
Yes	No	Diabetes	Yes	No	Lung Disease
Yes	No	Hypoglycemia-low blood sugar	Yes	No	Asthma
Yes	No	Rheumatic fever	Yes	No	Emphysema
Yes	No	Arthritis	Yes	No	Chronic sinus problems
Yes	No	Hepatitis	Yes	No	Psychiatric care
Yes	No	Cancer	Yes	No	Migraine headaches

Yes No Have you ever had an allergic reaction to any medication or latex?
If yes, describe_____
Yes No Are you currently taking any prescription drugs of any kind?
If yes, what?_____
Yes No Have you been advised to take an antibiotic pre-medication prior to dental treatment?
Yes No Are you pregnant? Anticipated delivery date_____
Yes No Do you use any tobacco product?
Yes No Do you wear contact lenses?

I certify the above to be true and correct, to the best of my knowledge

Signature_____ Date_____
Patient or Guardian of minor

Updates (date & initial) _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____