RYAN COX
ORTHODONTICS

Patient Information

Today's Date _____ ☐ Male ☐ Female

Name _____
Last First MI

Name Preferred _____
Date of Birth _____
Patient E-mail _____
Address _____
City _____ State _____ Zip _____
Employer _____
Occupation _____
☐ Cell ☐ Home # _____
Work # _____
☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed

Spouse _____
Address _____
City _____ State _____ Zip _____
Employer _____
Occupation _____
☐ Cell ☐ Home # _____
Work # _____

Responsible Party Information

Is the Responsible Party the same as the patient?
☐ Yes ☐ No (if no, please fill in the information below)

Name _____
Address _____
City _____ State _____ Zip _____
Employer _____
Occupation _____
☐ Cell ☐ Home # _____
Work # _____
E-mail _____

Medical/Dental History

General Dentist _____
Last Dental Visit _____
Is the patient under the care of a physician for a specific reason at this time? _____
Physician's Name _____
Are you taking any prescription medication?
☐ Yes ☐ No If so, which ones? _____
Are you taking medications for osteoporosis or osteopenia?
☐ Yes ☐ No
List any drug sensitivities _____
Please check all of the following that apply
☐ Diabetes ☐ TMJ Pain ☐ Heart Condition
☐ Epilepsy ☐ Bone Disorders ☐ Kidney Problems
☐ Hepatitis ☐ AIDS/HIV
Have you been informed of any missing/extra teeth?
☐ Yes ☐ No

Are there any other family members that you would like us to evaluate? ☐ Yes ☐ No

_____
Family members previously treated in our office?

_____
Who may we thank for referring you to our office?

_____

Insurance

Primary Dental Insurance
Insured's Name _____
Employer _____
Insurance Company _____
Date of Birth _____ SS # _____

Secondary Dental Insurance
Insured's Name _____
Employer _____
Insurance Company _____
Date of Birth _____ SS # _____

X _____
Signature of Parent/Patient/Guardian **Date**