Frank R. Marshall, DDS MS

Specialized Orthodontic Care
for Children, Adolescents & Adults

Patient Information

Name ______________________ ______________________ __________ Sex
Last First Middle

Address ______________________ ______________________ __________ __________
Street City State Zip

Birthdate ______________ E-mail ______________________ Social Security# ______________
MM-DD-YYYY 999-99-9999

Home Phone ______________ General Dentist ______________________ Last Visited ______________
999-999-9999

Whom may we thank for referring you to our office ______________________

Parents Information

Father

Name ______________________ ______________________ __________
Last First Middle Marital Status

Address ______________________ ______________________ __________ __________
Street City State Zip

Birthdate ______________ E-mail ______________________ Social Security# ______________
MM-DD-YYYY 999-99-9999

Home Phone ______________ Cell Phone ______________ Work Phone ______________ ext. __________
999-999-9999 999-999-9999 999-999-9999

Employer ______________________ Occupation ______________________ No. Years Employed __________

Relationship to Patient ______________________

Mother

Name ______________________ ______________________ __________
Last First Middle Marital Status

Address ______________________ ______________________ __________ __________
Street City State Zip

Birthdate ______________ E-mail ______________________ Social Security# ______________
MM-DD-YYYY 999-99-9999

Home Phone ______________ Cell Phone ______________ Work Phone ______________ ext. __________
999-999-9999 999-999-9999 999-999-9999

Employer ______________________ Occupation ______________________ No. Years Employed __________

Relationship to Patient ______________________

Insurance Information

Policy Owner's Name ______________________ Policy Owner's Employer ______________________

Insurance Company ______________________ Group No. (plan, local, or policy) ______________________

Insurance Co. Address ______________________ Insurance Phone No. ______________________

Do You have Dual Coverage

General Information

School ______________________

Hobbies

Brothers/Sisters (include ages)

Medical History

Medical Physician? ______________ Phone ______________ Last Visit ______________

Is the child currently under the care of a physician? ☐ Yes ☐ No If Yes, explain ______________

Has puberty begun? ☐ Yes ☐ No Has menstruation (period) begun? ☐ Yes ☐ No ☐ N/A

What are the main concerns that you would like orthodontics to accomplish? ______________

Has the patient ever been evaluated for orthodontic treatment? ☐ Yes ☐ No

Have the patient's tonsils or adenoids been removed? ☐ Yes ☐ No

Has the patient ever experienced jaw joint pain/ discomfort (TMJ/TMD)? ☐ Yes ☐ No

Does the patient have any missing or extra permanent teeth? ☐ Yes ☐ No

Has the patient ever had an injury to : (select all that apply) ☐ Teeth ☐ Mouth ☐ Chin

Has the patient ever had any of the following habits?

☐ Lip Sucking/Biting ☐ Nail biting ☐ Prolonged Bottle/Pacifier
☐ Clenching/Grinding Teeth ☐ Mouth Breather ☐ Tongue Thrusting ☐ Thumb/ Finger Sucking

Does the patient have speech problems? ☐ Yes ☐ No If Yes, explain ______________

Is the child allergic to any of the following?

☐ Aspirin ☐ Erythromycin
☐ Codeine ☐ Penicillin
☐ Tetracycline ☐ Latex
☐ Any Metals/Plastics

Other Allergies/Sensitivities:

____

List all drugs the Patient is currently taking

List any serious medical condition(s) treated

Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.
I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office.
I understand that where appropriate, credit bureau reports may be obtained.

Name of person filling out this form ______________ Date ______________