23522 Wilderness Oak, Suite 109
San Antonio, TX 78258
www.oaktreeorthodontics.com

Welcome To Oak Tree Orthodontics!

Patient Information

(Please complete all applicable fields to shorten your clinic appointment)

How did you hear about our office? _____

Patient's Name: _____ Preferred Name: _____

Birthdate: _____ Gender: _____ Which school do you attend: _____ Grade: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell#: _____ Home#:_____ Email: _____

Marital Status: _____ Occupation: _____ Employer: _____

Emergency Contact: _____Relationship: _____Contact #:_____

Responsible Party Information:

(Please complete if patient is a minor)

Guardian 1 (Last, First) _____ Birthdate:_____

Marital Status: _____ Relationship to patient: _____ Email: _____

Mailing Address: _____City: _____ State: _____ Zip:_____

Cell #: _____ Home#: _____

Guardian 2(Last, First): _____ Birthdate: _____

Marital Status: _____ Relationship to patient: _____ Email: _____

Mailing Address: _____City: _____ State: _____ Zip:_____

Cell #: _____ Home#: _____

Insurance Information:

(This information is required to verify policy and orthodontic benefits)

Primary Subscriber's Name: _____ Relationship to patient:_____
Social Security #_____ Birthdate: _____ Cell#_____
Mailing Address: _____City: _____ State: _____ Zip:_____
Employer: _____ ID# _____ Group# _____
Insurance Company: _____ Insurance Phone #_____

Secondary Subscriber's Name: _____ Relationship to patient:_____
Social Security #_____Birthdate: _____ Cell#_____
Mailing Address: _____City: _____State: _____ Zip:_____
Employer: _____ ID# _____ Group# _____
Insurance Company: _____ Insurance Phone #_____

Dental History Information

Dentist Name / Office Name: _____

What is the date of your last dental examination? _____ Any pending treatment?:_____

Do you have any fears/anxiety regarding dental appointments? Yes _____ No_____

Have Adenoids or Tonsils been removed? _____ If so when:_____

Have there been injuries to the face, mouth or chin? _____

Have you or anyone in your immediate family received orthodontic treatment? Yes _____ No _____

How did they feel about results? _____

Does/Did you have any of the following habits? Grinding Teeth Finger/Thumb Habit Speech Problems

Snoring, Mouth Breather, Lip Biting, Jaw Clicking or Popping etc_____

Are you currently being treated for or have ever been treated for any of the following? Please check all that apply: *(some conditions, medications and questions that appear personal may effect orthodontic treatment, please complete)*

YES	NO		YES	NO		YES	NO	
_____	_____	Diabetes	_____	_____	HIV/AIDS	_____	_____	Heart Murmur
_____	_____	Asthma	_____	_____	Epilespy	_____	_____	Hepatitis
_____	_____	Autism	_____	_____	Sinus problem	_____	_____	Cancer/Chemo
_____	_____	Anemia	_____	_____	Pregnant (Date:_____)	_____	_____	Congenital heart problem
_____	_____	Arthritis	_____	_____	Osteoporosis	_____	_____	Bleeding/Bruising
_____	_____	Gum disease	_____	_____	Tuberculosis	_____	_____	Artificial heart valves
_____	_____	Seizures	_____	_____	Artificial joint	_____	_____	Gum Disease
_____	_____	Sleep Apnea	_____	_____	Infective Endocarditis	_____	_____	Speech difficulty/therapy

Any other conditions not discussed?

_____

List all current medications:

_____

Are you allergic to any of the following? _____ Latex _____Penicillin ____Sulfa _____Codeine ____Tylenol

_____Ibuprofen _____Dental Anesthetics Other:_____

Do you like your smile? Yes ____ No ___ any concerns with your bite: _____

What is your main concern with your teeth/smile? _____

Hobbies _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand the information will be held in the strictest confidence, and that it is my responsibility to inform the office of any changes in my medical status.
By signing or sending this form to Oak Tree Orthodontics, you consent to our use and disclosure of your protected health information to communicate with your other healthcare providers and insurance company, carry out treatment, and healthcare operations. Have a beautiful day!

Signature:_____ Date:_____
(Parent/Guardian Signature if patient is a minor)