ZWANZIGER & BOE
ORTHODONTICS

## *Please Help Us Keep Your Information Updated!*

### UPDATED PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Date _____

Patient's Name _____
Last First Middle

Address _____
Street City Zip

Birthdate _____ School _____

**General Dentist** _____ **Date of last visit** _____

### RESPONSIBLE PARTY INFORMATION

Responsible Party's Name _____
Last First Middle

Address _____
Street City Zip

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____

Relationship to Patient _____

Employer _____ Occupation _____

Spouse's Name _____
Last First Middle

Relationship to Patient _____

Employer _____ Occupation _____

Parent Signature _____ Date _____

## DENTAL INSURANCE INFORMATION

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____

Group No _____ Local No _____

Insurance Co. Address _____ Phone No _____

Do you have dual dental coverage? Yes_____ No_____ If yes, please complete the following:

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____

Group No _____ Local No _____

Insurance Co. Address _____ Phone No _____

## EMERGENCY INFORMATION

Name of nearest relative not living with you: _____

Complete address _____
Street City Zip

Phone _____

## MEDICAL HISTORY

Physician _____ Date of Last Visit _____

**Please circle Yes or No (If Yes, please fill in details)**

Yes No Is the patient taking any medication? If yes, please list: _____
_____

Yes No Is the patient allergic to any medication? If yes, please list: _____
_____

Yes No History of a major illness? _____

Yes No Has the patient had any operations? _____

Yes No Ever been involved in a serious accident? _____

Yes No Have seen a physician in the last 12 months? Why? _____

**For Female Patients Only:**

Yes No Has menstruation started? _____

Yes No Is the patient pregnant? _____

**Circle any of the medical conditions below that the patient currently has or has had in the past:**

| | | | |
|---|---|---|---|
| Abnormal bleeding/Hemophilia | Diabetes | Hepatitis/Liver problems | Pneumonia |
| Anemia | Dizziness | Herpes | Prolonged Bleeding |
| Arthritis | Epilepsy | High Blood Pressure | Radiation/Chemotherapy |
| Asthma or Hayfever | Gastrointestinal Disorders | HIV / Aids | Rheumatic Fever |
| Bone Disorders | Heart Problems | Kidney problems | Tuberculosis |
| Congenital Heart Defect | Heart Murmur | Nervous Disorders | Tumor or Cancer |

Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

Parent Signature _____ Date _____