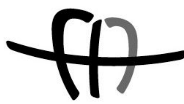


Farrar & Tipton
ORTHODONTICS

WELCOME!

Please fill out patient information

Today's Date:____/____/____

Patient Legal Name:____ **Preferred Name:**________________

Date of Birth____/____/____ **Sex: M F** **E-mail address**______________________________

Address____
Street City State Zip code

Phone #: _________________(cell/home/work) **Secondary Phone #:**_________________(cell/home/work)

Occupation and Employer:____

Siblings/Children:_____________________ **If applicable, Patient School Name:**________________________

Parent/Legal Guardian and/or Spouse Information:

Parents/Patient marital status: Married☐ Divorced ☐ Single☐ Widowed☐

☐Mother ☐Step Mother ☐Spouse or Other:________________________________

Name:_____________________________________ **Date of Birth:** ____/_____/_____

E-mail: _____________________________ **Phone Number:** ________________________ (cell/home/work)

Address____
Street City State Zip code

Occupation and Employer:____

☐Father ☐Step Father ☐Spouse or Other:________________________________

Name:____________________________________ **Date of Birth:** ____/_____/_____

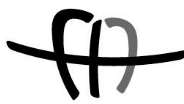
E-mail:______________________________ **Phone Number:** _____________________ (cell/home/work)

Address____
Street City State Zip code

Occupation and Employer:____

Orthodontic Insurance:

Orthodontic coverage? Y N
Insurance co. name:_______________________ **Insurance co. phone #:**______________________________
Insurance co. address: _____________________________ **Policy holder's employer:**____________________
Policy holder's name:_________________________ **Policy holder's Date of Birth:** _____/____/____
ID #:_________________ **Group #:**___________________ **Policy holder's SSN:**________________________



Patient Name:____

Family Physician:____

Family Dentist: _______________________ Last cleaning?______________

Whom may we thank for for referring you? __________________________

Medical History

Smoke or use of tobacco in any form? Y N
Has patient had any psychological counseling: Y N
Have metal rods, pins, or implants? Y N
Diagnosed or treated for any of the following:

☐ Asthma	☐ Neurological Disorder	☐ ADD/ADHD	☐ HIV/AIDS
☐ Seizures	☐ Autism /Aspergers	☐ Diabetes	☐ Hepatitis
☐ Allergies	☐ Currently Pregnant	☐ High Blood Pressure	☐ Anemia

***Please list any other allergies, medical or behavioral conditions:**

____
____
____

Does this patient require antibiotic premedication for dental treatment? Y N

Have there been injuries to the face, mouth or teeth? Y N
Has patient ever sucked their thumb/finger? Y N
Does patient breathe predominantly through their mouth? Y N
Does patient have any speech problems? Y N
Does patient experience clicking or discomfort in jaw joints? Y N
Does the patient grind or clench their teeth? Y N
Does the patient want orthodontic treatment? Y N
Does patient have any congenital abnormalities? Y N
Has patient been informed of any MISSING/EXTRA permanent teeth? Y N
Last physical within 1 year? Y N
Patient's current health is: Good Fair Poor
List ALL medication or over the counter drugs:

____