Clay Spencer DDS, MS *Patient* #_____

Specialist in Orthodontics

707 Lamar Avenue, Suite L · Paris, Texas 75460

Patient Information

Date _____ Age _____ Gender ☐M ☐F

Last First Middle

Patient's Name

Street City State ZIP

Address

Home Phone _____ Birth date _____ Social Security #_____

Email _____ School Name _____ Grade_____

If patient is a minor, give parent's or guardian's name that patient lives with_____

Have we treated other family members? Please list.

_____

What is your chief concern?_____

_____

Whom may we thank for referring you to our office?

_____

Dentist Name _____ Physician Name_____ Hobbies _____

Custodial Parent or Guardian Information

Last First Middle Marital Status

Name

Street City State ZIP

Address

Does the patient live at this address? ☐Yes ☐No Email _____

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security #_____ Birth date _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Last First Middle

Spouse's Name Relationship to Patient _____

Social Security #_____ Birth date _____ Work Phone _____

Employer _____ Occupation _____ No. Years Employed _____

Insurance Information

Last First Middle

Insured's Name Birth date _____

Social Security #_____ Employer _____ Insurance Co. _____

Insured's Address *(if different from above)* _____ Insured's Phone _____

Group No. _____ ID No. _____Ins. Co. Phone _____

Street City State ZIP

Insurance Co. Address

Do you have dual coverage? ☐Yes ☐No *If yes, please add secondary insurance information below.*

Last First Middle

Insured's Name Birth date _____

Social Security #_____ Employer _____ Insurance Co. _____

Insured's Address *(if different from above)* _____ Insured's Phone _____

Group No. _____ ID No. _____Ins. Co. Phone _____

Street City State ZIP

Insurance Co. Address

Emergency Information

Name of nearest living relative not living with you _____ Relationship _____

Street City State ZIP

Address

Phone _____ Alternate Phone _____

Medical Information

Yes	No		Yes	No		Yes	No
☐	☐	Heart Disease					
☐	☐	Blood Disease					
☐	☐	Thyroid Disease					
☐	☐	Bone Disease					
☐	☐	Cancer					

☐ ☐ Emotional or Nervous Problems
☐ ☐ Endocrine Problems
☐ ☐ Problems with Wound Healing
☐ ☐ Asthma
☐ ☐ Diabetes
☐ ☐ Epilepsy
☐ ☐ Heart Murmur
☐ ☐ Hemophilia
☐ ☐ Hepatitis
☐ ☐ HIV Positive
☐ ☐ Mitral Valve Prolapse
☐ ☐ Artificial Joints or Heart Valves
☐ ☐ Mononucleosis
☐ ☐ Prolonged Bleeding
☐ ☐ Rheumatism or Arthritis
☐ ☐ Rheumatic/Yellow/Scarlet Fever
☐ ☐ Tuberculosis
☐ ☐ Is Patient under Medical Care
☐ ☐ Is Patient in Good Health
☐ ☐ Women: Are you Pregnant
☐ ☐ Do you smoke or use tobacco
☐ ☐ Has the Patient Reached Puberty
☐ ☐ Are you Allergic to Anything

If yes, what: _____

_____

_____

☐ ☐ Are you aware of any other disease, condition, or problem not listed above that we should know about?

If yes, what:_____

_____

_____

List any medications: _____

_____

_____

Dental History

Yes No

☐ ☐ Has the patient seen a general dentist in the last year
☐ ☐ Has the mouth, face or teeth been injured by a fall or accident
☐ ☐ Have you been informed or missing or extra permanent teeth
☐ ☐ Are you aware of any "gum" or periodontal problems

☐ ☐ Has the patient's tonsils or adenoids been removed
☐ ☐ Has a physician or dentist advised antibiotics before a dental exam
☐ ☐ Any clicking or popping of the jaw
☐ ☐ Any jaw discomfort or pain

Do you have or ever had any of the following habits:

Yes No
☐ ☐ Thumb sucking
☐ ☐ Fingernail biting
☐ ☐ Clenching or grinding teeth
☐ ☐ Tongue thrusting
☐ ☐ Speech problems
☐ ☐ Have you been examined by an orthodontist before?

If yes, when: _____

I certify that the information on this form is correct. I understand that it is my responsibility to report any changes.

Signature of Patient _____ Date _____

For Office Use Only

File Only No/Cov Acc/Ins