PINES
PEDIATRIC DENTISTRY
& ORTHODONTICS

Your journey to a straight smile starts here!

Patient Information

Preferred Language: English Spanish French/Creole

Patient's Last Name: First Name:

Address: City: Zip:

Email: Phone #:

Referral Information

Where did you hear about us?

Name of person or office referring you to our practice:

Insurance Information

Insured's Name: Relationship to patient:

Insured's DOB: Insured's Social Security #:

Insurance Company: Group #: Member #:

Does your employer provide a flexible spending account (FSA): Yes No Not Sure

Medical History

Yes No Do you currently have or have had any medical problems?

If so, which:

Yes No Are you taking any medications? If so, which:

Yes No Do you have any allergies? If so, which:

Yes No Have you had any operations? If so, which:

Yes No Have you ever been involved in a serious accident?

If so, explain:

Female Patients:

Yes No Are you pregnant or plan on becoming pregnant?

Dental History

Primary Dentist: Date of Last Visit:

Yes No Have there been any injuries to the face, mouth, or teeth?

Yes No Any type of finger sucking or tongue habit?

Yes No Is the patient a mouth breather?

Yes No Do you ever have any jaw joint pain?

Yes No Tooth grinding or clenching?

Yes No Any speech problems?

About Today's Consultation

Reason for you visit today:

Yes No Have you ever had braces or other orthodontic treatment before?

Yes No Have you had a recent orthodontic consultation?

If so, with whom and when:

Yes No Are you willing to start treatment today if there is room in the schedule?

Do you have a preferred treatment option in mind? Check all that apply:

Braces Clear Braces Invisalign I don't know

I understand that my (or my child's) diagnostic records may be used for educational purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history.

Signature: Date: