Today's Date: _____

MARK L. UNDERWOOD, D.D.S, M. ED.
Orthodontics and Dentofacial Orthopedics

Pt# _____

We would like to welcome you to our office. Our goal is to make everyone's visit pleasant and educational.

Please fill out the information below:

Patient's Name: _____ Nickname: _____
LAST FIRST MI

Male Female Patient's Birthdate: ____/____/____ Patient's Age: _____ Home#: _____

Patient's Home Address: _____
APT / CONDO # CITY STATE ZIP

School: _____ Grade: _____ Hobbies / Sports: _____

Person accompanying patient today?

Name: _____

Do you have legal custody of this child? YES NO

Whom may we thank for referring you? _____

List brothers / sisters, with age(s): _____

General Dentist: _____ Last Visit Date: _____

Parents Marital Status: Single Married Widowed Divorced Separated

Mother's Information: Mother Stepmother Guardian

Name: _____ SS #: _____ Birthdate: ____/____/____

Home#: _____ Cell#: _____ Email: _____

Employer: _____ Work #: _____ Ext: _____

How long at current job? _____ Job Title: _____

Father's Information: Father Stepfather Guardian

Name: _____ SS #: _____ Birthdate: ____/____/____

Home#: _____ Cell#: _____ Email: _____

Employer: _____ Work #: _____ Ext: _____

How long at current job? _____ Job Title: _____

Person Responsible for Account: _____ SS #: _____

Billing Address: _____

Relation: _____ Work#: _____ Ext: _____ Home#: _____ Cell#: _____

Employer: _____

PRIMARY ORTHODONTIC INSURANCE:

Orthodontic Coverage: Yes No Insurance Co. Name _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____ Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____ Relation: _____

Policy Owner's Birthdate: ____/____/____ Policy Owner's SS #: _____

Policy Owner's Employer: _____

What are the main concerns that you would like orthodontics to address?

Has your child ever been evaluated for or had orthodontic treatment? Yes No

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

Have adenoids or tonsils been removed? Yes No

Has your child ever had any of the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Have any teeth been removed	Y	N	Clenching / Grinding Teeth
Y	N	Allergies to any Drugs	Y	N	Hearing Impairment	Y	N	Lip Sucking / Biting
Y	N	Allergic to Latex / Metals	Y	N	Heart Murmur	Y	N	Mouth Breather
Y	N	Asthma	Y	N	Hepatitis	Y	N	Nail Biting
Y	N	Cancer	Y	N	HIV+ / AIDS	Y	N	Speech Problems
Y	N	Congenital Heart Defect	Y	N	Kidney / Liver Problems	Y	N	Thumb / Finger Sucking
Y	N	Convulsuions / Epilepsy	Y	N	Rheumatic / Scarlet Fever	Y	N	Tongue Thrust
Y	N	Diabetes	Y	N	Tuberculosis (TB)			

Please discuss any medical problems that your child has had: _____

Please list all drugs your child is currently taking:

Please list all drugs your child is allergic to:

- **I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and is my responsibility to inform this office of any changes in my child's medical status.**

_____ Signature _____ Date

DO NOT WRITE BELOW THIS LINE

Molar Classification - Right _____ Left _____ Cuspid Classification - Right _____ Left _____

Crowding or Spacing evident _____

Overjet _____ Overbite _____ TMJ _____

Midlines _____

Crossbites _____

Oral Hygiene _____ Gingival conditions _____

Frenums _____ Tongue Mobility _____ Function _____

Other: _____

READY FOR RECORDS? Yes _____ No _____ RECALL _____ Mos. Panorex only _____