Dr. Jacob C. Daub, Specialist in Orthodontics for Children & Adults (262) 255-1550

NEW PATIENT HISTORY FORM

Date _____

Patient Information

Patient's Name _____ ***Male/Female***
Date of birth _____ *Home phone* _____ *Cell phone*_____
Address _____
*City, State ZIP*_____
Patient's Dentist _____
Patient's school/grade _____ *hobbies/sports* _____
If patient is a minor, list name(s) of parents/guardians _____
Parents are: __ *not married* __ *married* __ *divorced* __ *separated* __ *legal guardian*
List any stepparents: _____
Siblings' names and birth dates: _____

Responsible Party Information (for patients under age 18)

Name _____ *Relation to patient* _____
Address _____ *Birth date*_____
Email _____ *Home phone*_____ *Cell phone*_____
Employer _____ *Work phone* _____
Spouse's Name _____ *Relation to patient*_____
Address _____ *Birth date* _____
Email _____*Home phone*_____ *Cell phone* _____
Employer _____ *Work phone* _____

Dental Insurance Information

Insured's Name _____ *Social Security #* _____
Insurance co. name _____ *Phone #* _____
Insurance co. address _____
Member/ID # _____ *Group #*_____
Do you have dual coverage? Yes _____ No _____ *If yes, complete the following:*
Insured's name _____ *Social Security #* _____
Insurance co. name _____ *Phone #* _____
Insurance co. address _____
Member/ID # _____ *Group #* _____
Which Plan is Primary? _____ ***Secondary?***_____

Emergency Information

Name of nearest relative not living with you _____ *Phone #*_____
Complete address _____

Who can we thank for referring you to our office?_____

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MEDICAL HISTORY FORM

Name_____ **Date**_____

Patient's Medical History

Physician's name and phone number _____
What has your physician treated you for in the last two years? _____

Have you ever had or do you now have any of the following:

_____ *Prolonged bleeding*	_____ *Cancer*	_____ *ADD/ADHD*
_____ *Epilepsy/Seizures*	_____ *Anemia*	_____ *Autism/Asperger's syndrome*
_____ *Diabetes*	_____ *Fainting or dizziness*	_____ *Learning disorder*
_____ *Heart problems*	_____ *Tuberculosis*	_____ *Physical limits/disabilities*
_____ *Heart murmur*	_____ *Nervous disorder*	_____ *Latex allergy*
_____ *Rheumatic fever*	_____ *Endocrine problems*	_____ *Allergic to:*_____
_____ *Bone disorders*	_____ *Liver problems*	_____
_____ *Hepatitis*	_____ *Birth defects*	_____ *High/Low blood pressure*
_____ *Aids or HIV*	_____ *Asthma*	_____ *Depression/Mood disorder*

Please explain any medical conditions checked above: _____
_____
List any medications you currently take: _____
Have you had any operations? __ *No* __ *Yes- Please explain:*_____
Have you been hospitalized? __ *No* __ *Yes-Please explain:*_____
List any other medical concerns we should be aware of:_____
_____

Patient's Dental History

Do you have any of the following:

___ *Family members who have had orthodontics:* _____
___ *Teeth sensitive to hot/cold*
___ *Injuries to your face, jaw, mouth or teeth:* _____
___ *Root canals, crowns, or bridges*
___ *Bleeding gums, bad taste in mouth, chronic bad breath*
___ *Currently/previously sucking your thumb and/or fingers? What age?*_____
___ *Any clicking, popping or pain of the jaw, joints (TMJ)*
___ *Trouble chewing*
___ *Anxiety about dentistry*

*The date of your most recent dental exam?*_____
How often do you brush your teeth? _____ *How often do you floss?* _____

What is the main thing you would like to address with Dr Daub? What would you like to see different about your smile?_____
_____