TWO CONVENIENT LOCATIONS

NORTH LOOP 1604 LOCATION
8358 N. Loop 1604 W, Suite 101
San Antonio, TX 78249
Office: (210) 695-1116
www.psorthotx.com

ALAMO RANCH LOCATION
11923 Culebra Road
San Antonio, TX 78253
Office: (210) 981-6264

Confidential Patient Information Form

Patient Information

Patient's Full Name _____ Nickname _____ Age _____ Date of Birth _____

☐ Male ☐ Female Primary Phone # _____ Secondary Phone # _____

Do you like receiving text appointment reminders? Yes No (Please circle above phone number to receive text)

Address _____ State _____ Zip Code _____

Email Address _____(parent's if minor) Dentist _____ Last Appt _____

Whom may we thank for referring you to our office? _____

School _____ Hobbies _____

Other parties who may bring patient to appointments _____ Relationship to Patient _____

Patient Privacy Concerns_____

Responsible Party *(If Responsible Party is Patient, Skip Next 5 Lines)*

Full Name _____ Date of Birth _____ Relationship to Patient _____

☐ Male ☐Female Primary Phone # _____ Secondary Phone # _____

Do you like receiving text appointment reminders? Yes No (Please circle above phone number to receive text)

Address (check if same as above ☐) _____ State _____ Zip Code _____

Email address _____

Employer _____ Occupation _____ Years employed _____

How long at current residence _____ Marital Status _____

Spouse _____ Spouse's Employer _____ Years employed _____

Spouse's relationship to patient _____ Spouse's phone number _____

Insurance Information

Insured Name _____ Date of Birth _____ SSN _____

Insurance Company _____ ID# _____ Group # _____

Insurance Company Phone Number _____ Insured Employer _____

Insurance Company Address _____

Dual Coverage? ☐ YES ☐ NO

Co-Insured Name _____ Date of Birth _____ SSN _____

Insurance Company _____ ID# _____ Group # _____

Insurance Company Phone Number _____ Insured Employer _____

Insurance Company Address _____

Patient Name: _____

MEDICAL CHECKLIST

Does the patient have or ever had any of the following medical conditions?

☐ Allergies or asthma	☐ Cancer or tumor(s)	☐ Emotional Problems	☐ Hepatitis/liver disease	☐Rheumatoid arthritis
☐ Arthritis	☐ Cleft lip/palate	☐ Epilepsy or convulsions	☐ HIV or AIDS	☐ Sleep apnea/sleep disorders
☐ Breathing difficulties	☐ Diabetes	☐ Fainting or dizziness	☐ Kidney Problems	☐ Speech problems
☐ Bleeding disorders	☐ Ear Infections	☐ Hearing problems	☐ Learning Disabilities	☐ TMJ
☐ Bone Disorders	☐ Endocrine problems	☐ Heart disease or murmur	☐ Rheumatic fever	☐ Tuberculosis

Other medical conditions not listed: _____

MEDICAL HISTORY

Circle One:

Y N Does the patient have a health problem? Please list _____

Y N Is there a history of serious illness, accident or operation? Please list _____

Y N Is the patient under a doctor's care for any problems at this time? Please list _____

Y N Is the patient currently taking any medication? Please list _____

Y N Has the patient ever taken bisphosphonate medication? Please list _____

Y N Does the patient have any allergies or drug sensitivities (latex, penicillin, etc.)? Please list _____

Y N Does the patient have frequent headaches? How often? _____

Y N Does the patient use tobacco products? _____

DENTAL HISTORY

Date of last dental exam: _____

Circle One:

Y N Has the patient had any injury to the teeth? _____

Y N Has the patient had any injury to the face, jaws, or chin? _____

Y N Does the patient currently need any dental work to be completed (such as fillings or crowns)? _____

Y N Does the patient have any missing, extracted, or extra permanent teeth? _____

Y N Does the patient have any pain, clicking, or popping noises in the jaw? _____

Y N Does the patient clench or grind their teeth? _____

Y N Does the patient suck fingers, thumb, or have a similar habit? _____

Y N Has the patient had an orthodontic consultation recently? _____

Y N Has the patient had any previous orthodontic treatment? _____

Y N Have we treated any other family members? _____

Reason for seeking orthodontic treatment:

_____

_____

_____

EMERGENCY INFORMATION

Name of nearest relative not living with you: _____ Phone: _____

Address: _____

SIGNATURE

Patient Signature* (*Parent's signature if minor*) _____ Date: _____

**By signing, I agree that the information is true to the best of my knowledge. I have received the Privacy Policies of* Pierson & Saunders Orthodontics*. I understand that where appropriate credit bureau reports may be obtained.*