R&R
RED & RITCHEY
ORTHODONTICS

Date_____

Patient Name _____
First Middle Last Nickname

□ Male □ Female Age ____ Birthday____/____/_____ Phone_____

Cell Phone # _____ Cell Carrier _____(for appointment reminders)

Address_____ Patient lives with:_____

□ I am the responsible party: SS#____-___-____ Driver's License #_____

Employer_____ Work phone #_____ E-Mail Address_____

Biological Parents or Guardian

Father's Name_____ DOB____/____/____ SS#_____-____-_____

Driver's License #_____ Address _____

Phone #_____ E-Mail Address _____

Employer_____ Work Phone #_____

Mother's Name_____ DOB____/____/____SS#_____-____-_____

Drivers License #_____ Address _____

Phone #_____ E-Mail Address _____

Employer_____ Work Phone #_____

Step Parents

Stepfather's name_____ DOB____/____/____ SS#_____-____-_____

Driver's License #_____ Address _____

Phone #_____ E-Mail Address _____

Employer_____ Work Phone #_____

Stepmother's name_____ DOB____/____/____ SS#_____-____-_____

Driver's License #_____ Address _____

Phone #_____ E-Mail Address _____

Employer_____ Work Phone #_____

Insurance Information

Insured's Name _____ DOB_____/_____/_____

Insurance Company_____ Insurance Phone #_____

Subscriber ID #_____ Group # _____

Do you have dual coverage? □ Yes □ No If yes, complete the following:

Insured's Name _____ DOB_____/_____/_____

Insurance Company_____ Insurance Phone #_____

Subscriber ID #_____ Group #_____

DENTAL AND HEALTH HISTORY Dentist: _____

Address:_____Phone_____

Last Check-Up:____ /____/_____

Family Physician_____

Whom may we thank for referring you to this office?

_____

Has the patient received orthodontic treatment? _____

What type?_____

Is the patient under treatment by a physician or taking any medication?_____

For?_____ Pharmacy_____ Phone Number_____

PLEASE INDICATE YES OR NO AND CIRCLE ALL THAT APPLY.

Yes No Major Falls / Injuries / Operations Involving the Head or Teeth
Yes No Rheumatic Fever / Diabetes / Asthma / Convulsions / Fainting / Anemia
Yes No Mouth Sores / Herpes (Cold Sores) / AIDS / Infectious Hepatitis
Yes No Repeated Headaches / Sore Throats / Colds / Ear Infections
Yes No Does the patient require pre-medication for any type of medical condition?
Reason_____
Yes No Other Illness or Surgery:_____
Yes No Allergies to:_____Nickle?_____
Yes No Emotional Problems:_____
Yes No Speech Problems:_____
Yes No Any special eating problem or digestive disturbance?_____
Yes No Any difficulty swallowing or chewing food?
Yes No Does the patient: Vomit / Gag / Faint easily?
Yes No Any difficulty breathing through the nose?
Yes No Is the patient a mouth breather? While awake / While asleep
Yes No Habit: Thumb-sucking / Finger-sucking To what age? _____
Yes No Muscular twitches relating to: Teeth / Face
Yes No Pain on: Opening of mouth / Closing of mouth
Yes No Clicking on: Opening of mouth / Closing of mouth
Yes No Facial pain / Jaw pain
Yes No Nighttime: Teeth clenching / Teeth grinding
Yes No Repeated headaches due to problems with: Mouth / Teeth / Jaw
Yes No History of Periodontal Problems? If yes, Last Perio Check-Up_____
With who?_____
Yes No Any other problems relating to tonsils and/or adenoids?_____ Removed?_____Year? _____
Yes No Has patient reached puberty? Girl - Menstruation _____ Boy – Voice Change_____
Yes No Is patient sensitive or concerned about the appearance of his/her teeth?
Yes No Anyone else in the family have a similar dental condition, bite, or arrangement of teeth?
Yes No Has either patient or other children had orthodontic treatment?
Yes No Does patient play a musical instrument? If yes, what? _____

Please list two names and phone number in case of an emergency:

1)_____ Phone_____

2)_____ Phone_____