FORCIER ORTHODONTICS
DR. DARREN J. FORCIER, DDS

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PATIENT INFORMATION FORM

PERSONAL DETAILS

DATE: _____

Patient's full name: _____ Preferred name: _____ Date of Birth:

☐ Male ☐ Female Patient's Address: _____

Home phone number: _____ Cell phone number: _____

Email address: _____

Dentist's name: _____ Doctor's name: _____

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

IF UNDER THE AGE OF 18

Age: _____ School: _____ Musical instruments played: _____

Sports: _____ Hobbies: _____

Sibling names and ages: _____

Father's name: _____ Work phone: _____ Home phone: _____

Mother's name: _____ Work phone: _____ Home phone: _____

Patient lives with: _____

RESPONSIBLE PARTY

Name: _____ Marital status: _____ Spouses name: _____

Residence: _____

Mailing address: _____ How long at this address: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Previous address (if less than 3 years): _____ How long at this address: _____

Relationship to patient: _____ SSN: _____ Date of Birth: _____

Employer: _____ Occupation: _____ Number of years employed: _____

Additional email addresses for correspondence / notification: _____

INSURANCE INFORMATION

Insured name: _____ Date of birth: _____ SSN: _____

Insurance company: _____ ID #: _____ Group#: _____

Insurance Co. address: _____ Phone: _____

Insured employer: _____ Do you have dual coverage?: ☐ Yes ☐ No

Co-Insured name: _____ Date of birth: _____ SSN: _____

Insurance company: _____ ID #: _____ Group#: _____

Insurance Co. address: _____ Phone: _____

Insured employer: _____

info@smilewny.com | www.smilewny.com

Member American Association of Orthodontists

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Patient's 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 / disorder
☐ 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

☐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, nickel, etc.? Please list:_____

☐Y ☐N Does the patient have frequent headaches? Please list:_____

☐Y ☐N Does the patient use tobacco products? Please list:_____

DENTAL HISTORY

Date of last dental exam: _____

☐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 understand it is my responsibility to keep the office informed of any changes to the above. I give Dr. Forcier and his staff permission to examine and take any diagnostic records, such as, photographs, radiographs, and impressions, to completely diagnose and plan the course of treatment. I understand that where appropriate, credit bureau reports may be obtained. I also give the office permission to contact other health care providers and/or insurance carriers with information regarding my/my child's orthodontic care.

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