



Date: _____

No: _____

PLEASE PRINT IN INK

David M. Sarver DMD,MS

1705 Vestavia Pkwy

Birmingham, AL 35216

205-979-7072

Fax 205-979-7140

www.SarverOrtho.com

PATIENT INFORMATION

LAST NAME		FIRST NAME		NICKNAME		SSN		SEX	BIRTH DATE	AGE
MAILING ADDRESS				CITY		STATE	ZIP	HOME #		
SCHOOL (IF STUDENT)		GRADE	<input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOW		EMPLOYER/OCCUPATION			WORK #		
EMAIL					FAX #			CELL #		
WHO MAY WE THANK FOR RECOMMENDING US?					NAME OF DENTIST				DATE OF LAST VISIT	
RELATED PATIENTS THAT ARE OR HAVE BEEN UNDER OUR CARE					NAMES AND AGES OF OTHER CHILDREN					
1.					1.					
2.					2.					
3.					3.					
4.					4.					

PARENT INFORMATION (PLEASE COMPLETE IF PATIENT IS A MINOR)

FATHER'S NAME			SSN			MOTHER'S NAME			SSN		
ADDRESS						ADDRESS					
CITY			STATE	ZIP		CITY			STATE	ZIP	
EMAIL						EMAIL					
HOME #			CELL #			HOME #			CELL #		
EMPLOYER/OCCUPATION				WORK #		EMPLOYER/OCCUPATION				WORK #	

INFORMATION ABOUT PERSON RESPONSIBLE FOR THIS ACCOUNT

NAME		RELATION TO PATIENT			EMPLOYER/OCCUPATION					
MAILING ADDRESS			CITY		STATE	ZIP	HOME #			
WORK #		CELL #			FAX #		EMAIL			
INSURANCE COMPANY		CONTRACT NUMBER			GROUP NUMBER			GROUP MEMBER BIRTH DATE		
IF DIVORCE IS INVOLVED, WHO IS THE CUSTODIAL PARENT?					MAY PATIENT INFORMATION BE RELEASED TO THE NON-CUSTODIAL PARENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					



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MEDICAL HISTORY

PLEASE CHECK IF PATIENT HAS OR HAS HAD THE FOLLOWING:

- [] JOINT SWELLING [] TUBERCULOSIS
[] BONE DISORDERS [] ANEMIA
[] HEART TROUBLE [] EPILEPSY (CONVULSIONS)
[] MITRAL VALVE PROLAPSE [] PROLONGED BLEEDING
[] RHEUMATIC TROUBLE [] FAINTNESS/DIZZINESS
[] DIABETES [] TONSILS REMOVED
[] EMOTIONAL PROBLEMS [] ADENOIDS REMOVED
[] BRAIN INJURY [] SORE THROAT
[] KIDNEY OR LIVER INVOLVEMENT [] TONSILLITIS
[] JOINT PROSTHESIS [] EARACHES
HAVE YOU OR ANY MEMBERS OF YOUR FAMILY HAD:
[] RHEUMATOID ARTHRITIS? [] ARTHRITIS
[] LUPUS? [] LATEX ALLERGY
[] THYROID PROBLEMS

ON ITEMS CHECKED, PLEASE PROVIDE A MORE DETAILED DESCRIPTION:

IS PATIENT PRESENTLY UNDER PHYSICIAN CARE FOR ANY REASON?

NAME OF PRIMARY PHYSICIAN _____

OTHER _____

LIST ANY OTHER SERIOUS ILLNESSES

ADOLESCENT FEMALES: HAS MENSTRUATION BEGUN?

DATE MONTH/YEAR _____

APPROX. HOW MUCH HAS THE PATIENT GROWN IN THE LAST YEAR? _____

DENTAL HISTORY

PLEASE CHECK IF PATIENT HAS OR HAS HAD THE FOLLOWING:

- [] ANY INJURIES TO FACE, MOUTH, OR TEETH
[] THUMB, FINGER, OR LIP SUCKING
[] MORE THAN AVERAGE AMOUNT OF TOOTH DECAY
[] EXTRA PERMANENT TEETH
[] TEETH REMOVED BY EXTRACTION
[] DIFFICULTY IN SWALLOWING OR CHEWING
[] ANY PAIN OR CLICKING WHEN OPENING MOUTH
[] IS THE PATIENT ADOPTED? AT WHAT AGE? _____
[] PREVIOUSLY CONSULTED BY ANOTHER ORTHODONTIST
[Y] [N] DOES THE PATIENT VISIT THE DENTIST REGULARLY?
DATE OF LAST VISIT _____

ON ITEMS CHECKED, PLEASE PROVIDE A MORE DETAILED DESCRIPTION:

LIST DRUGS OR MEDICATIONS NOW BEING TAKEN

DO YOU TAKE ANY MEDICATIONS FOR OSTEOPOROSIS? [Y] [N]

IF YES, PLEASE LIST: _____

LIST ANY ALLERGIES

WHAT DO YOU WANT TO ACCOMPLISH WITH ORTHODONTIC TREATMENT?

PATIENT'S ATTITUDE TOWARD ORTHODONTIC TREATMENT:

VERY MOTIVATED WILL COOPERATE IF NEEDED NOT MOTIVATED

WE ARE SORRY THAT WE CANNOT ACCEPT DIVORCE DECREES AS ASSIGNMENTS OF RESPONSIBILITY FOR A CHILD'S ORTHODONTIC BILLS. THE PARENT ACCOMPANYING THE CHILD SHOULD PAY FOR THE SERVICES AND SEND ANY REIMBURSEMENT FROM THE OTHER PARENT. TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS COMPLETE AND CORRECT. I GIVE MY PERMISSION FOR ANY PHOTOGRAPHS, X-RAYS, OR STUDY MODELS TO BE USED FOR DISPLAYS AT SCIENTIFIC MEETINGS, PRESENTATIONS, AND PUBLICATIONS OF A SCIENTIFIC NATURE OR FOR STUDY GROUP PURPOSES TO FURTHER THE ART AND SCIENCE OF ORTHODONTICS. I, THE UNDERSIGNED, AGREE TO PAY FOR ATTORNEY FEES AND OTHER COSTS OF COLLECTIONS IN THE EVENT IT BECOMES NECESSARY TO USE ATTORNEY SERVICES TO SECURE PAYMENT OF THIS ACCOUNT.

Signature _____ Date _____