Drs. Shannon & Shannon, Inc.

ORTHODONTICS

For Children and Adults

PATIENT INFORMATION

Patients Name	Last	First	Middle
Address	Street		
	City	State	Zip
Home Phone	Birth date	E-mail address	
If patient is a minor, give parent's or guardian's name.			
Is the patient male or female? Male Female			
Whom may we thank for referring you to our office ?			

RESPONSIBLE PARTY INFORMATION

Name			Marital Status
Last	First	Middle	
Residence	Street		
	City	State	Zip
Mailing Address	Street		
	City	State	Zip
Home Phone		Work Phone	
Birth date		Relationship to Patient	
Employer		E-mail address	
Spouse's Name			Relationship to Patient
Last	First	Middle	
Employer		Work Phone	

INSURANCE INFORMATION

Insured's Name	Insured's Social Security # or ID#
Insurance Company	Insured’s Date of Birth
Insurance Company Phone Number	
Insured’s Employer	
Do you have dual coverage ? Yes No If yes, complete section below	
Insured's Name	Insured's Social security # or ID#
Insurance Company	Insured’s Date of Birth
Insurance Company Phone Number	
Insured's Employer	

AUTHORIZATION AND RELEASE

I authorize the release of information necessary to process the insurance claims. I authorize insurance benefits to be made directly to Drs. Shannon and Shannon, Inc.

Signature Date

EMERGENCY INFORMATION

Name of nearest relative not living with you	
Address	Phone Number

PATIENT DENTAL HISTORY

What are the main concerns that you would like orthodontics to accomplish ?

	Yes	No
Have you ever been evaluated for orthodontic treatment ?		
Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)?		
Do you like your smile?		
Do your gums ever bleed?		
Do you have any speech problems? If yes, explain		
Do you generally breathe through your mouth while awake?		
Do you generally breathe through your mouth while asleep?		
Have there been any injuries to the face, mouth teeth or chin?		
Do you have missing or extra permanent teeth?		
Have adenoids or tonsils been removed?		

If patient is a child does/did your child have any of the following habits?

Please Circle

Clenching / Grinding Teeth	Nursing Bottle Habits
Lip Sucking / Biting	Speech Problems
Thumb / Finger Sucking	Tongue Thrust
Nail Biting	

General Dentist

Date of Last Visit

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? PLEASE CIRCLE

Aspirin	Erythromycin	Other Antibiotics
Any Metals / Plastics	Penicillin	Latex
Codeine	Tetracycline	Dental Anesthetics

Please list any other drugs that you are allergic to :

Have you had previous skin reactions to jewelry or know of an allergy to any metal?

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS? PLEASE CIRCLE

Abnormal Bleeding	Heart Attack / Stroke	Kidney Problems
Any Hospital stays	Heart Murmur	Ulcers / Colitis
Any Operations	Heart Surgery / Pacemaker	Venereal Disease
Hepatitis	High / Low Blood Pressure	Severe / Frequent Headaches
Artificial Bones / Joints	Anemia/Radiation Treatment	Epilepsy / Seizures
Artificial Valves	Mitral Valve Prolapse	Fainting Spells
HIV+ / AIDS	Psychiatric Problems	Hearing Impairment
Asthma / Arthritis	Rheumatic / Scarlet Fever	Handicaps / Disabilities
Blood Transfusion	Shingles	Diabetes
Cancer / Chemotherapy	Sinus Problems	Fever Blisters / Herpes
Congenital Heart Defect	Emphysema	Drug / Alcohol Abuse
Tuberculosis (TB)	Glaucoma	Difficulty Breathing

Are you pregnant? Yes No Week Number

Please list all drugs or medications you are taking.

Are you under the care of a physician ? Yes No
Please Explain

Family Physician

Phone Number Date of Last Visit