ORTHODONTICS of ATLANTA
Your Smile is our Specialty!

WELCOME TO OUR OFFICE!

Patient Information

***Name*_____*Last*_____*Age*____*BirthDate*_____*Female*☐*Male*☐**

Marital Status Single☐ *Married*☐ *Divorced*☐ *Widowed*☐ *Separated*☐

*Home Address*_____*City*_____*State*_____*Zip code*_____

*Cell phone#*_____ *E-Mail*_____

*General Dentist*_____*Last visit*_____*How did you hear about us*_____

*Do we treat someone you know?*_____

***Insurance: Yes*_____ *No*_____ *Policy Number:*_____**

If Minor

*Mother's Name/Last name*_____*Father's Name/Last name*_____

School Name _____*Grade*_____

Address(if different from above) _____*City*_____*State*_____*Zip code*_____

*Mother's Employer*_____*Mother's work No.* _____

*Father's Employer*_____*Father's work No.* _____

*Sibling's Names &BirthDates*_____

MEDICAL HISTORY/DENTAL HISTORY

YES	NO		YES	NO		YES	NO	
☐	☐	Joint swelling	☐	☐	High Blood Pressure	☐	☐	Any missing permanent teeth
☐	☐	Bone Disorder	☐	☐	Bleeding Problem	☐	☐	Any teeth removed by extraction
☐	☐	Heart Trouble	☐	☐	Tuberculosis	☐	☐	Any difficulty in swallowing or chewing
☐	☐	Thyroid Problem	Other_____			☐	☐	Any pain or clicking on opening mouth
☐	☐	Rheumatic Trouble	Name of the Physicians_____			☐	☐	Allergies _____
☐	☐	Diabetes	☐	☐	Are You Pregnant	☐	☐	Consulted other Orthodontist before?
☐	☐	HIV/AIDS	☐	☐	Any Injuries to Face, Mouth, Teeth	*What is your main concern that you would like to accomplish with orthodontics?*		
☐	☐	Anemia	☐	☐	Thumb, finger, lip sucking			
☐	☐	Kidney/Liver Proble						

Date_____ Signature_____

www.orthodonticsofatlanta.com

Please provide Insurance card to front staff (if any)