Today's Date _________________ **J. Mickey Damerell, DDS, MS, Inc.** T.C.________ A B C

Patient Information

Patient's Name____Nickname______________________________
Last First Middle

Address____
Street City State Zip

Home #________________________Birthdate________________Sex________Age_________Social Security #_______________________ (O K to telephone office with SS#)

School/Employer____Sports/Hobbies_____________________________________

If patient is a minor, give parent's or guardian's name____

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

Email Address:
____

Responsible Party Information

Name____Marital Status________________
Last First Middle

Residence____
Street City State Zip

Mailing Address____
Street City State Zip

How long at this address______________Home #__________________Work #____________________Cell #________________________

Previous Address (if less than 3 yrs.)____
Street City State Zip

Social Security#__________________________(O K to telephone office with SS#)
Birthdate___________________Relationship to Patient______________________________

Employer ______________________________Occupation_________________No. Years Employed_______________________________

Spouse's Name____Relationship to Patient______________________________

Employer________________________________Occupation_________________No. Years Employed________________________________

Social Security #________________________(O K to telephone office with SS#)
Birthdate___________________Work#___________________Cel #_____________________

Dental Insurance Information

Policy Holder's Name____Social Security #___________________________________(O K to telephone office with SS#)

Insurance Company____Group No.____________________Union Local No.___________________________

Insurance Co. Address____Insurance Co. Phone_______________________________

Policy's Holder's Employer____

Do you have dual coverage? No ____ Yes___ If yes:
Policy Holder's Name____Social Security #___________________________________(O K to telephone office with SS#)

Insurance Company____Group No.____________________Union Local No.____________________________

Insurance Co. Address____Insurance Co. Phone________________________________

Policy's Holder's Employer____

Emergency Information

Name of nearest relative not living with ____Relationship____________________________

Complete Address____

Home #_________________________________Work#______________________________Cell#____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (parent's signature if minor)____Date__________________

Medical Information

	YES	NO
Do you anticipate moving off island in the near future?…………………………………………………………	+	-
Has anyone in the family ever had orthodontic care?…………………………………………………………..	+	-
Has the patient had a previous orthodontic examination?……………………………………………………	+	-
If yes, when and by whom ____		
Does the patient's mouth look like anyone else's in the family?…………………………………………………	+	-
Has patient reached puberty?…………………………………………………………………………………………	+	-

Has menstruation begun? (Girls Only) When?……………………………………………………………………. +
-

History of mouth breathing, finger/thumb sucking, nail biting, bruxism (grinding teeth)……………………… +
-

Have tonsils and/or adenoids been removed?……………………………………………………………………. +
-

Date: ___________________________

History of Heart trouble, rheumatic fever, diabetes, bleeding disorders?………………………………………. +
-

History of liver or kidney problems, epilepsy, endocrine disorders?…………………………………………….. +
-

History of malignancy (cancer) or radiation treatment?…………………………………………………………….. +
-

History of fainting or dizziness, nervousness or hyper-activity?…………………………………………………… +
-

History of ear infections, sore throats, frequent colds, asthma, or allergies?…………………………….…. +
-

History of HTLV-III virus, cytomegalovirus, veneral disease, AIDS?………………………………………………. +
-

Hiistory of injury to face, head, or teeth?…………………………………………..……………………………….. +
-

History of hearing or speech problems?……………………………………………………….…………………….. +
-

Are you taking or have ever taken: Major Biophosphonate medication.………………………………………….

alendronate (Fosamax) etidronate (Didronel) ibandronate (Boniva)
pamidronate (Aredia) risedronate (Actonel) zolendronate (Zometa)………………………………… +
-

Are you taking any medication for Osteoporosis, Myeloma, Matastatic Cancer or other Bone Disease?……. + -
If, yes, list medication:______________________________________

Does Patient have a health problem now?………………………………………………………………………….……
+ -

Family Dentist____Last Cleaning____

Family Physician____

Please list all drugs that patient is currently taking:
____

Please list all drugs that patient is allergic to:
____

Any questions or comments?
____

Thank you for supplying this information