**DARCY C. CRUIKSHANK, DMD, MSD, LLC**
**DAVID L. CRUIKSHANK, DDS, PC**
*SPECIALISTS IN ORTHODONTICS*

*Today's Date*_____

**Patient's First Name** **Middle Initial** **Last Name** **Nickname** **Date of Birth** **Age** **Gender**

**Patient's Dentist** **Referred By** **Patient's School & Grade**

**Orthodontic Insurance Carrier** **Insurance Phone Number** **Medical Savings Plan?**

Who is accompanying the patient today?_____Relationship to patient?_____

With whom does the patient live?_____Who receives treatment information?_____

Who is financially responsible for this account?_____Adopted?_____

Parent's marital status? Married_____Separated_____Divorced_____Domestic Partnership_____Widow(er)_____Remarried_____Single_____

**Patient's Parent (Mother/Father)**

First Name_____

Last Name_____

Social Security #_____

Date of Birth_____Gender_____

Address_____

City/State/Zip_____

Home Phone_____

Cell Phone_____

E-mail_____

Occupation_____

Employer_____

City/State_____

Work Phone_____

Would you like to receive e-mail reminders? ☐ Yes ☐ No

Would you like to receive text message reminders? ☐ Yes ☐ No

If yes; Cell Phone Carrier_____

**Patient's Parent (Mother/Father)**

First Name_____

Last Name_____

Social Security #_____

Date of Birth_____Gender_____

Address_____

City/State/Zip_____

Home Phone_____

Cell Phone_____

E-mail_____

Occupation_____

Employer_____

City/State_____

Work Phone_____

Would you like to receive e-mail reminders? ☐ Yes ☐ No

Would you like to receive text message reminders? ☐ Yes ☐ No

If yes; Cell Phone Carrier_____

**PRIMARY DENTAL INSURANCE COMPANY**

Insured Party_____

Relationship to patient_____

Employer_____

Bus. Address_____

Date of Birth_____SS#_____

Ins. Co. Name_____

Address_____

Group #_____Group Name_____

Subscriber I.D. #_____

**SECONDARY DENTAL INSURANCE COMPANY**

Insured Party_____

Relationship to patient_____

Employer_____

Bus. Address_____

Date of Birth_____SS#_____

Ins. Co. Name_____

Address_____

Group #_____Group Name_____

Subscriber I.D. #_____

**Any other adults responsible for care**?_____

Relationship to patient_____ Relationship to patient_____

Last Name_____ Last Name_____

First Name_____ First Name_____

Address_____ Address_____

Phone_____ Phone_____

**Primary concern with teeth:**_____

_____

_____

Has the patient been under the care of a physician during the past two years?_____

Physician's name _____City_____

Is the patient taking any medication or drugs?_____

Does the patient have a history of major illness or hospital stay?_____

**Please check the following that the patient has been diagnosed with:**

- ☐ Allergies (seasonal)
- ☐ Allergies (metal)
- ☐ Allergies (latex)
- ☐ Allergies (medication)
- ☐ Asthma
- ☐ Congenital Defects
- ☐ Behavorial/Learning problems
- ☐ Diabetes (Type:_____)
- ☐ Epilepsy
- ☐ Headaches (Frequency_____)
- ☐ Heart Murmur
- ☐ HIV/Aids
- ☐ Injury to face/jaw (Please explain below)
- ☐ Rheumatic Fever
- ☐ Psychiatric Illness (examples: depression, bipolar, anxiety)
- ☐ Tuberculosis

Describe other medical concerns:_____

Special needs:_____

Have tonsils and adenoids been removed? If yes, what age?_____

Has the patient ever sucked a thumb or fingers? If yes, until what age?_____

Has the patient or other family members had any previous orthodontic treatment?_____

Has the patient been informed of any missing or extra permanent teeth?_____

Does the patient have any jaw pain or noise in the jaw joint?_____

Does the patient play a musical instrument (mouth only)? If yes, hours /day_____

**Girls only**: Have menstrual periods started? If yes, at what age?_____

Is there a possibility of pregnancy? Expected delivery date_____

**Boys only**: Voice change? Facial Hair? If yes, at what age?_____

**Patient's Siblings**

Name Date of Birth_____

_____

_____

_____

May we thank someone for referring you to our office?_____

Signature Today's date_____