Convoy Dental
Pediatrics • Orthodontics • Adults

Welcome to Convoy Dental!
We are so excited you chose *us* for
your Orthodontic needs!

Today's Date: ______________________________

Patient Name: ____
First Middle Last (Nickname)

Birthdate: _____/_____/_____ Age:___________ Male □ Female □

Appointment Reminders: Text □ Email □ Both □

Best Phone #: (_____)_______________ Email Address: ____

Address: ____

____
CITY STATE ZIP

General Dentist: ___________________________________ Last Date Seen by General Dentist: _________________

Who may we thank for referring you?: ____

List family members that are currently in our practice?: ____

Has the patient had previous Orthodontic Treatment? Yes □ No □

What are your chief complaints you would like to discuss with Dr. Pfeffer?: __________________________________

____

Has the patient ever had the following medical problems?

Y N Abnormal Bleeding
Y N Allergies to any drugs
Y N Any Hospital Stays
Y N Any Operations
Y N Asthma
Y N Cancer
Y N Congenital Heart Defect
Y N Convulsions / Epilepsy
Y N Diabetes
Y N Handicaps / Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis
Y N HIV+ / AIDS
Y N Kidney / Liver Problems
Y N Rheumatic / Scarlet Fever
Y N Tuberculosis (TB)
Y N Frequent Colds
Y N Frequent Sore Throats
Y N High/Low Blood Pressure

Please discuss any medical problems that the patient has had:____

____

Has the patient had any injuries to the face, mouth, or teeth? Yes □ No □ If yes, please explain:________________________

Please list all drugs that the patient is currently taking: ____

Please list all drugs/materials that the patient is allergic to: ____

Has the patient ever has any pain/tenderness in his/her jaw joint (TMJ / TMD)?: Yes □ No □

Does the patient have the following habits? If yes, till what age?:_____________________________________

Y N Lip Sucking / Biting **Y N** Nail Biting **Y N** Nursing Bottle Habits **Y N** Thumb / Finger Sucking

For Women: Are you pregnant? **Y N** Are you nursing? **Y N** Are you using birth control? **Y N** Has menstruation started? **Y N**

Responsible Party Information

Mother's Name: ______________________________ Birthdate: _____/_____/_____

Cell #: (_____)______________________________ Work #: (_____)_______________ Ext.: ______

SS #: ____ Occupation: ____________________________

Step Mother □ Guardian □

Father's Name: ______________________________ Birthdate: _____/_____/_____

Home #: (_____)______________________________ Work #: (_____)_______________ Ext.: ______

SS #: _______________________________________ Occupation: ____________________________

Step Father □ Guardian □

Parent's Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated

Who is financially responsible for charges?: ____

Name Relation to Patient

If different from above, Billing address: ____

____

CITY STATE ZIP

Primary Dental Insurance

Insurance Co. Name:_________________________________

Insurance Co. Address:_______________________________

____

Insurance Co. Phone #: (_____)________________________

Group # (Plan, Local, or Policy #):

____

Policy Owner's Name:

____

First Middle Last

Relationship to Patient: ______________________________

Policy Owner's Birthdate: _____/_____/_______

SS#: ____

Policy Owner's Employer: ___________________________

Orthodontic Coverage? Yes □ No □

Secondary Dental Insurance

Insurance Co. Name:_________________________________

Insurance Co. Address:_______________________________

____

Insurance Co. Phone #: (_____)________________________

Group # (Plan, Local, or Policy #):

____

Policy Owner's Name:

____

First Middle Last

Relationship to Patient: ______________________________

Policy Owner's Birthdate: _____/_____/_______

SS#: ____

Policy Owner's Employer: ___________________________

Orthodontic Coverage? Yes □ No □