SHIRCK Orthodontics

FOR OFFICE ONLY
Verified Patient Info _____

Medical History Information

Date ___________________

Patient Name ____Age __________ Birthdate _______________________

Street Address ____ Male ______ Female ______

City ____State _________________Zip _________________

Patients Cell ________________________________ Carrier Verizon Sprint ATT Other_____________

Fathers Name (for Minors) ________________________Cell# ________________________ Carrier Verizon Sprint ATT Other______

Mothers Name (for Minors) ________________________Cell# _________________________ Carrier Verizon Sprint ATT Other______

Family Dentist _____________________ List any family member seen by Shirck Orthodontics _______________________

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

- ☐ **HEART TROUBLE**
- ☐ **MITRAL VALVE PRO**
- ☐ **HEART MURMUR**
- ☐ **RHEUMATIC FEVER**
- ☐ **PNEUMONIA**
- ☐ **HIV/AIDS**
- ☐ **ANEMIA**
- ☐ **EPILEPSY**
- ☐ **ASTHMA**
- ☐ **FAINT/DIZZY**
- ☐ **ATTENTION DEFICIT DISORDER**
- ☐ **KIDNEY PROBLEMS**
- ☐ **ENDOCRINE PROBLEMS**
- ☐ **PROLONGED BLEEDING**
- ☐ **TUBERCULOSIS**
- ☐ **LIVER INVOLVEMENT**
- ☐ **HEPATITIS**
- ☐ **BLOOD DISORDERS**
- ☐ **DIABETES**
- ☐ **OTHER**_________

Does patient have tendency to: TMJ___ Ringing in the Ears___ Headaches/Migraines___? If yes, has patient been treated for these concerns and how? ____

Have tonsils and adenoids been removed?_________ If yes, at what age?_______

List any medications being taken and reason for ____

LIST ANY ALLERGIES OR DRUG SENSITIVITY____

Financially Responsible Party Information

Name ________________________________ Relationship to Patient ______________ Date of Birth___________

Address (if different from patient) ____

Cell Phone ____________________ Carrier Verizon Sprint ATT Other______ Email _________________________

Dental Insurance Carrier Information

Member Name _________________________ Relationship to Patient ______________ Date of Birth___________

Member Address (if different from patient) ____

Cell Phone ____________________ Carrier Verizon Sprint ATT Other______ SSN#__________________________

Insurance Company ____________________ Member ID________________ Employer_____________________

In an effort to grow in our industry, we would love to hear all the ways in which you have heard about Shirck Orthodontics. We really appreciate your feedback!

Please place an "X" next to each of the WAYS in which you heard about us.

___ Insurance
___ Internet
___ Invisalign Website
___ Mailer/Postcard
___ Drive By/Saw Sign

___ Magazine Publication ______________
___ Friend/Family ____________________
___ School Sponsorship _______________
___ Sport Banner ____________________
___ Billboard, Where?_________________

___ Dentist ____________________
___ Staff _______________________
___ Sport Event _________________
___ Community Event _____________
___ Radio_______________________

Signature____ **Date**________________________________