Sophie Markovich, DMD, P.C.
Family Orthodontics

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WELCOME TO OUR OFFICE

Please answer all of the questions below in as much detail as possible.
All information is held in strict confidence.

Today's date: _____ E-mail _____
Patient's name: _____ Female/Male: _____
Preferred Name (Nickname): _____
Age: _____ Date of Birth: _____ Home Phone: _____
Address: _____
City: _____ State: _____ Zip: _____
School: _____ Grade: _____
Special Interests/Sports: _____ Family Dentist: _____

Parent: _____ Home Phone: _____
Address: _____
City: _____ State: _____ Zip: _____
Employed By: _____ Daytime / Cell Phone: _____

Parent: _____ Home Phone: _____
Address: _____
City: _____ State: _____ Zip: _____
Employed By: _____ Daytime / Cell Phone: _____

Person Responsible for this account? _____
Relationship to the patient: _____
Please list patient's brothers and sisters:
Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____

Yes __ No__ Is the patient in good health?
Yes __ No__ Does the patient have any history of major illness?
Yes __ No__ Has the patient been under the care of a physician for an illness in the past 2 years? If so, please describe with dates, and physician names:

_____
_____

Check any of the following for which the patient has been treated or now has:

__Aids/HIV
__Allergies/Asthma
__Anemia
__Arthritis
__Blood Disease
__Bone Disorders
__Diabetes
__Fainting/Dizziness
__Epilepsy
__Head, Face Injury
__Hearing Disorders
__Heart Disease
__Hepatitis
__High/Low Blood Pressure
__Psychological Disorder
__Kidney Disease
__Liver Disease
__Lung Dis./TB
__Pregnancy
__Rheumatic Fever
__Endocrine Disorder

Comments: _____

OVER ☞

If applicable, please write the name, dosage, and purpose of all prescription drugs that your child is taking and please identify any allergies:

Prescription Drugs	Allergies
_____	_____
_____	_____
_____	_____
_____	_____

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

Has your child had his/her tonsils and/or adenoids removed? If so, which? _____

Has your child made mention of any pain, clicking, popping or locking in the jaw joints? If so please describe: _____

Has your child had any orthodontic treatment, consultation, or orthodontic guidance in the past? If so, please describe when, and what took place (braces on top teeth and/or bottom teeth, extractions, headgear, retainers, or other pertinent facts): _____

_____

_____

Does your child have, or did have a thumb or finger sucking habit?

If so, please tell us how and when: _____

What is your primary concern in seeking an orthodontic evaluation? _____

What questions do you hope to have answered at today's initial evaluation appointment?

1._____ 2._____

3._____

INSURANCE Dental Insurance ❑ Yes ❑ No Orthodontic Insurance ❑ Yes ❑ No

Insured: _____ D.O.B. _____ ID # ____/____/____ Group # _____

Employer: _____

Insurance Company: _____ Insurance Co. Phone _____

Insurance Company Address: _____

The above questions have been fully and accurately an swered to the best of my knowledge. I will keep the office informed of any changes in medical condition. I authorize treatment for the patient named above and agree to be responsible for payment of all services rendered on my behalf or my dependents.

Parent or Responsible Party: _____ Date: _____

Relationship to Patient: _____

Thank you for thoughtfully completing this acquaintance form!