Howard F Vincent, Jr., D.M.D.

Specialist in Orthodontics

Date_____ Date of Birth_____

Name_____ Age____ Male □ Female □
First Middle Last

Name patient Prefers to be called_____

Address_____Phone #_____
School /Employer _____ Grade/Occupation_____ Patient's Dentist_____
Last Visit to Dentist_____ Patient's Hobbies or Interest_____
Responsible Party E-mail Address (allows access to x-rays, financials, etc.)_____
Please list names of other children in family if applicable. _____
Please list any family members previously treated here._____
Is there someone other than your dentist that we may thank for referring you to our office?
(friends, patients, neighbors, etc.) _____

Responsible Party Information

Name _____ Relationship to patient_____
Employer_____Work #_____ Occupation_____
Spouse's Name (if applicable)_____
Employer_____ Work #_____ Occupation_____
Marital Status of Responsible Party: Married □ Divorced □ Separated □ Single □ Widowed □

Does patient have insurance that covers orthodontic treatment? Yes□ No □ If yes, then:

Name of Insured_____ Relationship to patient_____
First Middle Last

Employer_____(if different than above)
Insurance Co._____Date of birth_____
Employee ID (or SS#)*_____ Phone # of insurance Co._____
***(Insurance companies are required to provide an I.D. # other than your Social Security number for prevention of I.D. theft)**

Is patient covered under another dental plan? Yes□ No □ If yes, please complete the following :

Name of Insured_____ Relationship to patient_____
First Middle Last

Employer_____ Occupation_____
Insurance Co._____ Date of birth_____
Employee ID (or SS#)*_____ Phone # of insurance Co._____

Medical/Dental History

Is the patient under the care of a physician for a specific problem at this time? Yes□ No□ Illness_____
List any medications patient is currently taking_____
List any drug sensitivities_____
Is there a history of major illness, accident or operation?_____
Adolescent patients only: Is the patient adopted? Yes□ No□
Has the patient reached puberty? Girls: Has she started menstruation? Yes□ No□ If yes, month/year_____
Boys: Has his voice changed? Yes□ No□

Please check all of the following that apply:

Diabetes □	Heart Trouble □	Grinding of Teeth □	Kidney Problems □	High Blood Pressure □
Hepatitis □	Allergies/Asthma □	Rheumatic Fever □	Bleeding Problems □	Bone Disorders □
Epilepsy □	Jaw Joint Pain □	Endocrine Problems □	Nervous Disorders □	Liver Disease □ AIDS/HIV □

Have you been informed of any missing or extra teeth? Yes□ No□
Has an orthodontist been consulted previously? Yes□ No□
Have you had any previous orthodontic treatment? Yes□ No□ If so, by whom?_____

_____
Signature of Parent, Patient or Guardian