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Orthodontics for Adults and Children
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CONFIDENTIAL PATIENT INFORMATION

Patient's Name _____ D/O/B: _____

If patient is a minor, need parent(s) or guardian(s) name(s):

Address: _____ City: _____ Zip: _____

Home

Phone: _____ Mobile: _____ Work: _____

SS #: _____ Family Physician: _____

Patient's general dentist: _____ Date of last exam: _____

School: _____ **Grade:** _____ **Sports:** _____

Hobbies: _____ Musical Instruments: _____

Email Address: _____

Patient/Parent is: Single Married Widowed Separated Divorced

Who may we "thank" for referring you to our office: _____

How many children do you have? _____ Their ages? { } { } { } { } { } { } { } { }

Responsible Party Information

Name: _____

Address: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

Relationship to Patient: _____ SS#: _____ D/O/B: _____

Employer: _____ Occupation: _____ Years Employed: _____

Spouse: _____ SS# _____ D/O/B: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

Relationship to Patient: _____ Employer: _____

Occupation: _____ Years Employed: _____

Chief Complaint

What is your chief complaint? _____

What do you expect from your treatment? _____

Medical & Dental History

Have you ever seen an orthodontist before? _____ Who? _____

Was any treatment provided? _____

Please 'X' all that apply:

Tonsils/Adenoids Removed _____	Headaches _____	Grinding/Clenching _____
Periodontal therapy _____	Mouth breathing _____	Clicking/popping in jaw _____
Rheumatic fever _____	Hep A, B, C _____	Trauma to head/face _____
Difficulty opening wide _____	Epilepsy _____	Surgery to head/face _____
High Stress _____	Pregnant _____	AIDS _____ Cancer _____
Frequent neck/backaches _____	Sinus Problems _____	Speech Problems _____
Frequent earaches _____	Arthritis _____	ADD/ADHD _____
Difficulty breathing through your nose _____		

Heart problems: If yes, please explain: _____

Smoke or smokeless tobacco: _____ If yes, how many packs per day? _____

Medications? If yes, please list all (including herbal or homeopathic):

Any other health problems: _____

ALLERGIES: _____

Emergency Information:

Name: _____ Relationship: _____

Home Phone: _____ Work: _____ Cell: _____

Insurance Information:

Insured Name: _____ SS# _____

Insurance Company: _____ Group #: _____

Do you have dual coverage: YES NO If yes:

Insured Name: _____ SS# _____

Insurance Company: _____ Group #: _____

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest confidence, and it is my responsibility to inform you of any changes in the patient's health. I authorize the dental staff to perform the necessary dental services on the patient. I further authorize the release of any necessary information or records to my insurance company.

Signature of Patient or Parent/Guardian

Date