

**RIVERSIDE ORTHODONTICS
NEW PATIENT FORM**

Patients Name _____ Age _____ Date of Birth _____ Sex _____
 Last **First** **Initial**
Address _____ Zip Code _____ Phone (____) _____
Social Security # _____ - _____ - _____ E-Mail Address _____ @ _____
School / Employer _____ Work Phone (____) _____ Alt. Phone (____) _____

If Patient is a minor, please fill out Responsible Party Portions

Responsible Party _____ Social Security # _____ - _____ - _____
 Last **First** **Initial**
Address _____ Zip Code _____ Phone (____) _____
Employer _____ Work Phone (____) _____ Relationship to Patient _____
E-Mail Address _____ @ _____ Alt. Phone (____) _____

Responsible Party _____ Social Security # _____ - _____ - _____
 Last **First** **Initial**
Address _____ Zip Code _____ Phone (____) _____
Employer _____ Work Phone (____) _____ Relationship to Patient _____
E-Mail Address _____ @ _____ Alt. Phone (____) _____

Person Responsible For Payments _____

Dentist Name _____ Address _____
Orthodontic Insurance Name and Address _____ Group # _____ ID # _____
Physician _____ Referred By _____ Subscribers Date of Birth _____

Social Data

Favorite Hobbies, Sports, Interests _____
Any Habits such as Finger Sucking or Nail Biting _____
Describe your child's temperament _____
Do you have any other concerns? _____

Medical History

General Health _____ Allergies _____
Any major illness, or periods of hospitalization? _____
Are you taking any medications? _____
Accidents (medical or dental) _____

Circle any for which patient has been treated

Diabetes	Kidney Involvement	Pneumonia	Endocrine Problems	Tuberculosis
Heart Trouble	Rheumatic Fever	Hepatitis / Liver Problems	Prolonged Bleeding	Anemia
Bone Disorder	Fainting or Dizziness	Seizure/ Epilepsy	HIV/ Aids	Asthma

Dental History

Have you ever received orthodontic treatment? Yes No
Have you ever been treated for or have knowledge of Periodontal or TMJ problems? _____

To the best of my knowledge the information above is accurate and complete. I authorize Dr. Kesselman and/or staff to provide dental treatment and I agree to be responsible for expenses incurred. I understand it to be my responsibility to inform this office of any medical changes.

Signature _____ Date _____

Relationship _____