Dean & Reagin Orthodontics

Dr. Charles Dean III
Dr. K. Britt Reagin

Patient Information

Date ____________ Home Phone ____________
MM DD YYYY

Patient's Name ____________ Date of Birth ____________
Last First Middle

Preferred Name (Nick Name) ____________ Male ☐ Female ☐ SS# ____________

Residence ____________
Street Number Street Suite/Apt City State ZIP

If patient is a minor, who is legal guardian ____________ Relationship to Patient ____________

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

Responsible Party Information

Name ____________ Marital Status ____________
Last First Middle

Residence ____________
Street Number Street Suite/Apt City State ZIP

Mailing Address ____________
(If Different than residence) Street Number Street Suite/Apt City State ZIP

How long at this address ______ Home Phone ______ Work Phone ______ Cell Phone ______
Years

Previous Address ____________
(If less than 3 years) Street Number Street Suite/Apt City State ZIP

Employer ____________ Occupation ____________ Time at Current Employment ______
Years

Employer Address ____________
Street Suite/Apt City State ZIP

Date of Birth ____________ Social Security Number ____________ Relationship to Patient ____________

Spouse's Name ____________ Relationship to Patient ____________
Last First Middle

Date of Birth ____________ Social Security Number ____________ Work Phone ____________

Employer ____________ Occupation ____________ Time at Current Employment ______
Years

Insurance

Primary Insurance Company Name ____________ Policy/Group # ______ Telephone ______

Insurance Company Address ____________
Street Suite/Apt City State ZIP

Primary Insurance Held By ____________ SS# ____________
(Whose name is on the insurance policy) Last First Middle If not given above

Secondary Insurance Company Name ____________ Policy/Group # ______ Telephone ______

Sec. Insurance Co. Address ____________
Street Suite/Apt City State ZIP

Sec. Insurance Held By SS#
(Whose name is on the insurance policy) Last First Middle If not given above

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IN CASE OF EMERGENCY Please contact ____________ Telephone ____________
(nearest relative not living with you) First Last

Complete Address ____________
Street Suite/Apt City State ZIP

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Medical History

Family Physician ______ Date of Last Visit ______ Are you in good health? Yes ☐ No ☐

Have you experienced any of the following: For all yes answers please provide specifics below:

Condition	Yes	No	Specifics
Sinus Problems	☐	☐	Specifics: ______
Ear/Nose/Throat Problems	☐	☐	Specifics: ______
Eye Problems	☐	☐	Specifics: ______
Muscle/Neural Problems	☐	☐	Specifics: ______
Bone Problems	☐	☐	Specifics: ______
Hormone Problems	☐	☐	Specifics: ______
Blood Problems	☐	☐	Specifics: ______
Kidney/Liver Problems	☐	☐	Specifics: ______
Urinary/Bladder Problems	☐	☐	Specifics: ______
Stomach/Intestinal Problems	☐	☐	Specifics: ______
Heart/Lung Problems	☐	☐	Specifics: ______
Head/Neck Problems	☐	☐	Specifics: ______
Back/Shoulder Problems	☐	☐	Specifics: ______

Allergies ☐ Metal ☐ Latex ☐ Drugs (Please List) ______
☐ Foods (Please List) ______ ☐ Other (Please List) ______

Please check any that apply:

Childhood/One Time Diseases	Heart Problems		Breathing Problems	Chronic Diseases	
☐ Mumps	☐ Murmur	☐ High Blood Pressure	☐ Asthma	☐ Tuberculosis	☐ Cancer
☐ Measles	☐ Chest Pain	☐ Heart Valve Problem	☐ Hay Fever	☐ Hepatitis A	☐ Diabetes
☐ Chicken Pox	☐ Angina	☐ Heart Failure/Attack	☐ Wheezing	☐ Hepatitis B	☐ HIV/AIDS
	☐ Palpations	☐ Coronary Disease	☐ Chronic Cough	☐ Hepatitis C	☐

Any other health problems or surgeries: ______

List any medications now being taken: ______

Dental History

Family Dentist ______ Date of Last Visit ______ Yearly Checkups? One ☐ Two ☐ Never ☐

	Yes	No	
Jaw or Face Injury/Trauma	☐	☐	☐ Broken Jaw ☐ Other (Explain) ______
Tooth Injury/Trauma	☐	☐	☐ Broken ☐ Chipped ☐ Lost
Mouth Habits	☐	☐	☐ Thumb/Finger Sucking ☐ Lip/Tongue Habits Until Age
Bleeding Gums	☐	☐	☐ After Brushing ☐ After Flossing ☐ All times
Ever Had Speech Therapy?	☐	☐	Advised By: ______ For: ______
Jaw Joint Pain	☐	☐	Explain: ______
Jaw Joint Popping/Clicking	☐	☐	☐ Both Sides ☐ Right Side ☐ Left Side

Fun stuff about you:

How do you feel about braces? ______

What are you most excited about changing in your smile? ______

Sports or hobby interests ______

What name do you prefer (nickname) ______ What pets do you have? ______

Any questions for Dr. Dean
or Dr Reagin? ______

I understand and certify that the information I have given on this form is correct and that I am obligated to inform Dean and Reagin Orthodontics immediately if any of this information changes in the future.

Signature of Patient or Parent/Guardian if patient is a minor ______