



Welcome to our Office!

Date ____/____/____

Patient's Name _____ Male / Female

Address _____ City _____ Zip _____

Date of Birth ____/____/____ Phone _____ Cell _____

Parent Name _____ Parent Name _____

Parent Cell/Work _____/_____/_____ Parent Cell/Work _____/_____/_____

Email address _____

School _____ Grade _____

Patient's Dentist _____ Date of Last Visit ____/____/____

Who Referred You to Our Office? _____

Dental History

What are your chief concerns? _____

How does the patient feel about braces? Enthused _____ Agreeable _____ Hesitant _____

Who first noticed orthodontic problems? Pt. M F Dentist

Did you or do you do any of the follow?

Do you or have you had?

Clench or Grind Teeth Y / N

Extra / Missing Teeth Y / N

Suck Thumb Y / N

Teeth that have been Extracted Y / N

Breathe with mouth open Y / N

Previous Ortho Consultation Y / N

Brush Daily Y / N

Previous Ortho Treatment Y / N

Injury to the mouth Y / N

Medical History

Patient's Physician _____ Date of last check-up ____/____/____

Heart Problems Y / N _____

Chronic Diseases Y / N _____

Medications presently taking Y / N _____

Do you pre-medicate before appt. Y / N _____

Allergies/ Drug Reactions Y / N _____

Operations/ Hospitalizations Y / N _____

Play instruments/ Sports Y / N _____

Anything else Dr. Anthony should know? Y / N _____



Richard Anthony, DDS MS, A Professional Corporation,
4165 Blackhawk Plaza Circle, Suite 260 • Danville, CA 94506 • 925-736-3311
fax: 925-736-3313 web: blackhawkortho.com email: dranthony@blackhawkortho.com



Insurance Information

Name of Insured _____ Relation to Pt. _____

Address _____ City _____ Zip _____

Home Phone _____ Cell _____ Work _____

Date of Birth ____/____/____ Social Security # _____

Dental Insurance Company _____ Phone _____

Employer _____ Insured ID # _____ Group # _____

Emergency Information

Name of nearest relative not living with you _____

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____

I hereby authorize release of any information to other health care providers, insurance companies, and business associates including personal health information as well as administrative data which is not strictly dental or medical in nature. I additionally authorize payment directly to Richard Anthony, DDS MS for insurance benefits otherwise payable to me.

I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

I certify that the information on this form is complete and true to the best of my knowledge.

Signature (Parent's signature if minor) _____

Medical History Changes or Updates

Signature (Parent's signature if minor) _____ Date ____/____/____

Signature (Parent's signature if minor) _____ Date ____/____/____



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