



Date: \_\_\_\_\_

**Fort Worth Office**  
4200 Bryant-Irvin Road, Suite 117  
Fort Worth, Texas 76109  
**PHONE:** (817) 731-8401  
**FAX:** (817) 377-4317  
**EMAIL:** info@kupermanortho.com

**Burleson Office**  
240 SW Wilshire Boulevard  
Burleson, Texas 76028  
**PHONE:** (817) 295-7124  
**FAX:** (817) 295-1429  
**EMAIL:** info@kupermanortho.com

### Patient Information

Name \_\_\_\_\_  
LAST FIRST MIDDLE  
Email (Home) \_\_\_\_\_ (Work) \_\_\_\_\_  
Home Address \_\_\_\_\_  
STREET CITY/STATE ZIP  
Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Social Security No. \_\_\_\_\_  
School/Employer \_\_\_\_\_  
If patient is a minor, give parent or guardian's name \_\_\_\_\_  
Whom may we thank for referring you to our office? \_\_\_\_\_

### Responsible Party Information

(this portion must be filled out completely)

Name \_\_\_\_\_  
LAST FIRST MIDDLE **S M D W**  
Marital Status  
Email (Home) \_\_\_\_\_ (Work) \_\_\_\_\_  
Home Address \_\_\_\_\_  
STREET CITY/STATE ZIP  
Mailing Address \_\_\_\_\_  
STREET CITY/STATE ZIP  
How long at this address? \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Previous Address (if less than 3 years) \_\_\_\_\_  
Social Security No. \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

### Responsible Party Spouse Information

Spouse's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Email (Home) \_\_\_\_\_ (Work) \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_  
Social Security No. \_\_\_\_\_ Birthdate \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

### Primary Dental Insurance Information

Insured's Name \_\_\_\_\_ Insured's Social Security No. \_\_\_\_\_  
Email (Home) \_\_\_\_\_ Insured's Birthdate \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_ Phone \_\_\_\_\_

### Secondary Dental Insurance Information

Insured's Name \_\_\_\_\_ Insured's Social Security No. \_\_\_\_\_  
Email (Home) \_\_\_\_\_ Insured's Birthdate \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_ Phone \_\_\_\_\_

I understand that, where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) \_\_\_\_\_ Updates (dates & initials) \_\_\_\_\_

## Emergency Information

Name of Emergency Contact \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Address \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

## Medical History

Physician \_\_\_\_\_ Date of last visit \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

Please circle Yes or No (if Yes, please fill in details)

Yes No Are you taking any medication(s)? \_\_\_\_\_  
Yes No Are you allergic to any medication(s)? \_\_\_\_\_  
Yes No Do you have a history of a major illness? \_\_\_\_\_  
Yes No Have you had any major operations? \_\_\_\_\_  
Yes No Have you ever been involved in a serious accident? \_\_\_\_\_

Check any of the medical conditions below that you have had or currently have

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Abnormal bleeding/Hemophilia | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Hepatitis/Liver problems | <input type="checkbox"/> Pneumonia              |
| <input type="checkbox"/> Anemia                       | <input type="checkbox"/> Dizziness                  | <input type="checkbox"/> Herpes                   | <input type="checkbox"/> Prolonged Bleeding     |
| <input type="checkbox"/> Arthritis                    | <input type="checkbox"/> Epilepsy                   | <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Radiation/Chemotherapy |
| <input type="checkbox"/> Asthma/Hayfever              | <input type="checkbox"/> Gastrointestinal disorders | <input type="checkbox"/> HIV/Aids                 | <input type="checkbox"/> Rheumatic Fever        |
| <input type="checkbox"/> Bone Disorders               | <input type="checkbox"/> Heart Problems             | <input type="checkbox"/> Kidney problems          | <input type="checkbox"/> Tuberculosis           |
| <input type="checkbox"/> Congenital Heart Defect      | <input type="checkbox"/> Heart Murmur               | <input type="checkbox"/> Nervous Disorders        | <input type="checkbox"/> Tumor/Cancer           |

Are there any medical conditions we have not discussed that you feel we should be aware of? \_\_\_\_\_  
\_\_\_\_\_

## Dental History

Dentist \_\_\_\_\_ Date of last visit \_\_\_\_\_

What concerns you most about your teeth? \_\_\_\_\_

Goals desired in seeking orthodontic care? \_\_\_\_\_

Please circle Yes or No (if Yes, please fill in details)

Yes No Are you presently in any dental pain? \_\_\_\_\_  
Yes No Have you ever experienced any unfavorable reaction to dentistry? \_\_\_\_\_  
Yes No Have you ever injured any teeth? \_\_\_\_\_  
Yes No Have there been any injuries to your face, mouth or teeth? \_\_\_\_\_  
Yes No Is any part of your mouth sensitive to temperature or pressure? \_\_\_\_\_  
Yes No Do your gums bleed when you brush? \_\_\_\_\_  
Yes No Do you have any type of thumb or tongue habit? \_\_\_\_\_  
Yes No Are you a mouth breather? \_\_\_\_\_  
Yes No Have you ever seen an orthodontist? If yes, who and when? \_\_\_\_\_  
Yes No Is your attitude positive toward receiving orthodontic treatment? \_\_\_\_\_  
Yes No Has anyone in your family received orthodontic treatment? \_\_\_\_\_  
How did they feel about the result? \_\_\_\_\_  
Yes No Do your teeth or jaws ever feel uncomfortable when you wake up in the morning? \_\_\_\_\_  
Yes No Are you aware of your jaw clicking or popping? \_\_\_\_\_  
Yes No Are you aware of clenching your teeth during the day? \_\_\_\_\_  
Yes No Have you ever been told that you grind your teeth? \_\_\_\_\_  
Yes No Do you have "tension" headaches? \_\_\_\_\_  
Yes No Have you ever experienced chronic ringing in your ears? \_\_\_\_\_  
Yes No Are you aware that some appointments will be during school/work hours? \_\_\_\_\_  
If the patient is under age 16, height of parents? Mom \_\_\_\_\_ Dad \_\_\_\_\_ Patient \_\_\_\_\_  
Please list some hobbies or interests \_\_\_\_\_

Female Patients only

Yes No Are you pregnant? Due Date \_\_\_\_\_  
If patient is under the age of 18, age menstruation began \_\_\_\_\_

Male Patients only

If patient is under the age of 18, age voice changed \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_