**PREMIER ORTHODONTICS**

**Medical Dental History Form for Patients under the age of 18 years**

**PATIENT INFORMATION**

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

Patient’s Legal Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *(Last) (First) (Middle)*

Prefers to be called: \_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_ years \_\_\_\_months

 *Mo. Day Yr.*

Patient’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *(Street) (City) (Zip)*

Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient lives with: ( ) Both Parents Together ( ) Father Primarily ( ) Mother Primarily

Is orthodontic insurance available? ( )None ( )Father ( ) Mother ( )Both ( ) Step-Father ( ) Step-Mother

Patient’s Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ You were recommended to our office by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###### FAMILY INFORMATION

**Father:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *(Last Name) (First Name) (Middle Initial)*

Social Security Number\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address *(if different from patient’s)*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­\_\_\_\_\_\_­­­­­­­­­

Home Phone *(if different from patient’s):* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Dental Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(Please give dental card to receptionist to copy for file.)*

**Mother:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *(Last Name) (First Name) (Middle Initial)*

Social Security Number\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address *(if different from patient’s)*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone *(if different from patient’s):* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Dental Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(Please give dental card to receptionist to copy for file.)*

 \*For insurance purposes

#### PERSON RESPONSIBLE OF ACCOUNT

##### Check one: ( ) Parents ( ) Split Bill Between Parents ( ) Father Only ( ) Mother Only ( ) Guardian

## AUTHORIZATION

**I consent to the orthodontist’s use and disclosure of my records (or my child’s records) to carry out treatment, to obtain payment and for those activities and health care operations that are related to treatment or payment. I acknowledge that I have had an opportunity to review the office privacy notice and I am in agreement with the office privacy practices.**

**I consent to the disclosure of my records, treatment information, appointments, etc. (or my child’s) to the following persons who are involved in my care (or my child’s care) or payment for that care (i.e. step-parent, grand-parent). My consent to disclosure of records shall be effective until I revoke it in writing.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print Name Relationship to Patient Print Name Relationship to Patient**

**I hereby authorize payment of the orthodontic insurance benefits to be made directly to Premier Orthodontics. I understand that I am responsible for all costs of diagnosis and treatment not paid by the insurance company. I hereby authorize the orthodontic office to administer and perform such diagnostic and treatment procedures as may be necessary for proper orthodontic care. The information on this page and the medical history are correct to the best of my knowledge. I will notify the orthodontist of any changes in my child’s medical or dental health.**

# SIGNATURE OF RESPONSIBLE PARTY

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

 *( ) Father ( ) Mother ( ) Guardian*

**HEALTH HISTORY and PATIENT INFORMATION**

*Your careful and completed answers to the following questions will be very helpful in the evaluation of your orthodontic problem*

**PATIENT’S NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last medical examination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_ Present Health? Good \_\_\_\_\_\_\_\_\_\_ Fair \_\_\_\_\_\_\_\_\_\_ Poor \_\_\_\_\_\_\_\_\_\_

Any history of a major illness? Yes \_\_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the patient been under the care of a physician during the past two years other than for routine examination? Yes/ No

***Check any of the following for which the patient has been treated***:

Diabetes \_\_\_\_\_\_ Heart problems \_\_\_\_\_\_ Bone disorders \_\_\_\_\_\_ Hepatitis \_\_\_\_\_\_ Bleeding disorders \_\_\_\_\_\_ Joint pain \_\_\_\_\_\_

 Anemia \_\_\_\_\_\_ Ear infections \_\_\_\_\_\_ Headaches \_\_\_\_\_\_

 Epilepsy \_\_\_\_\_\_ Hormone disorders \_\_\_\_\_\_ Convulsions \_\_\_\_\_\_

 Aids / HIV \_\_\_\_\_\_ Sinus infections \_\_\_\_\_\_ Dizziness ­­\_\_\_\_\_\_

 Allergies \_\_\_\_\_\_ Asthma / Hay fever \_\_\_\_\_\_ Arthritis \_\_\_\_\_\_

If you answered yes to any of these questions, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does patient vomit, gag, or faint easily? Yes \_\_\_\_ No \_\_\_\_

Does patient have tendency for colds? \_\_\_\_ sore throats? \_\_\_\_ ear infections? \_\_\_\_ Yes \_\_\_\_ No \_\_\_\_

Have tonsils and adenoids been removed? What age? \_\_\_\_\_\_\_\_

List any allergies or drug sensitivity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Present drugs or medications being taken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does patient have arthritis or pain in any joints of the body? Yes \_\_\_\_ No \_\_\_\_

Has the patient ever been treated for mental stress, nerves or any emotional problem? Yes \_\_\_\_ No \_\_\_\_

How many times a week does the patient have a headache? None \_\_\_ Few \_\_\_ Many \_\_\_\_

How many times a week does the patient take Aspirin, Tylenol or other pain medications? None \_\_\_ Few \_\_\_ Many \_\_\_\_

**==========================================================================================**

Has the patient reached puberty? Yes \_\_\_\_ No \_\_\_\_

Approximate increase in height in the last 6 months \_\_\_\_\_ inches.

**DENTAL HISTORY**

Has the patient had any injury of any type to the face, teeth, chin, or jaws? Yes \_\_\_\_ No \_\_\_\_

 Give details of any injuries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the patient been involved in any automobile, bike, skateboard, swimming pool, or any

other sporting accident? Yes \_\_\_ No \_\_\_\_ Give details of any injuries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Has patient ever had any pain in the jaw joints? Yes \_\_\_\_ No \_\_\_\_

Has patient ever had any clicking or popping sounds from the jaw joints? Yes \_\_\_\_ No \_\_\_\_

Has patient ever had a time when the jaw couldn’t open or close? Yes \_\_\_\_ No \_\_\_\_

Has the patient had any muscle pain, tiredness or stiffness of the jaw or neck? Yes \_\_\_\_ No \_\_\_\_

Does the patient grind or clench teeth? While awake? \_\_\_\_\_ While asleep? \_\_\_\_\_ Yes \_\_\_\_ No \_\_\_\_

Has the patient had any problems with sore or bleeding gums? Yes \_\_\_\_ No \_\_\_\_

Does the patient have any speech problems? Yes \_\_\_\_ No \_\_\_\_

Does the patient play a musical instrument? Yes \_\_\_\_ No \_\_\_\_

Are there any parts of the mouth or any teeth that are sore to pressure or irritants?

 (cold, hot, sweets, biting hard foods etc. ) Yes \_\_\_\_ No \_\_\_\_

Has the patient had any unusual dental experiences? Yes \_\_\_\_ No \_\_\_\_

 Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any medical, dental or surgical problems not covered above? Yes \_\_\_\_ No \_\_\_\_

 Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***The following are some habits of interest to Dr. Quraishi. List information as it pertains to the patient*.**

Thumb sucking until age \_\_\_\_ years Tongue thrusting Yes \_\_\_\_ No \_\_\_\_

Finger sucking until age \_\_\_\_ years Mouth breathing Yes \_\_\_\_ No \_\_\_\_

Lip biting or lip sucking Yes \_\_\_\_ No \_\_\_\_ Nail biting Yes \_\_\_\_ N0 \_\_\_\_

Other habits Yes \_\_\_\_ No \_\_\_\_ Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***(PLEASE COMPLETE THE OTHER SIDE )***

**PATIENT’S ATTITUDE TOWARD TEETH, FACE AND ORTHODONTIC TREATMENT:**

**What are the patient’s or parent’s main concerns regarding the jaws and teeth?**

Crowding \_\_\_ Deep bite \_\_\_ “Buck teeth” \_\_\_ Receding jaw \_\_\_

Spaces \_\_\_ Open bite \_\_\_ “Under bite”\_ \_\_\_ Prominent jaw \_\_\_

Neck pain \_\_\_ Gum disease \_\_\_ Clicking jaw \_\_\_ Headaches \_\_\_

Jaw pain \_\_\_ Gummy smile \_\_\_ Missing teeth \_\_\_ Face proportions \_\_\_

Overbite \_\_\_ Shape of teeth \_\_\_ Habits \_\_\_ Others \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Orthodontic consultation prompted by:

 Dentist \_\_\_\_ Patient \_\_\_\_ Mother \_\_\_\_ Father \_\_\_\_

 Physician \_\_\_\_ Friend \_\_\_\_ Sibling \_\_\_\_ Spouse \_\_\_\_

 Other ( specify ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s interest in orthodontic treatment and braces:

 Wants treatment \_\_\_ Treatment if necessary \_\_\_

 Unwilling but agrees \_\_\_ Uncooperative \_\_\_

Was patient aware of any orthodontic problem? Yes \_\_\_\_ No \_\_\_\_

Patient brushes teeth:

 Several times a day \_\_\_ Nearly every day \_\_\_ Rarely \_\_\_

 Once a day \_\_\_ Occasionally \_\_\_ Never \_\_\_

Dental check-ups:

 Twice a year \_\_\_ Once a year \_\_\_ Only if urgent \_\_\_ Never \_\_\_

Date of last dental check-up: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Next visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the dentist ever placed the patient on an oral hygiene program? Yes \_\_\_\_ No \_\_\_\_

Has the patient had deciduous (baby) teeth or permanent teeth removed or extracted? Yes \_\_\_\_ No \_\_\_\_

Are there other family members with a similar orthodontic condition? Yes \_\_\_\_ No \_\_\_\_

 Mother \_\_\_\_ Father \_\_\_\_ Sister \_\_\_\_ Brother \_\_\_\_

Has anyone in the family had orthodontic treatment? Yes \_\_\_\_ No \_\_\_\_

 Mother \_\_\_\_ Father \_\_\_\_ Sister \_\_\_\_ Brother \_\_\_\_

Has the patient had a previous orthodontic consultation and / or treatment? Yes \_\_\_\_ No \_\_\_\_

 When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dr.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What school subject does the patient like best? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are the patient’s favorite hobbies, sports, or pastimes? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you aware that appointments will infringe on school time? Yes \_\_\_\_ No \_\_\_\_

Do you wish to talk to the orthodontist privately about any special problem? Yes \_\_\_\_ No \_\_\_\_

Additional Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of individual completing this form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**====================================================================================**

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