Mallory G. Scott D.M.D, M.S.D

Patient Information

☐Male ☐Female

Name _____Date of Birth _____Age:_____

Address _____ City_____ Zip_____

Cell # _____ Home # _____ Work #_____

School _____ General Dentist_____ Last visit _____

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

What is your primary concern about your or your child's teeth?_____

Are you interested in Treatment with Invisalign?_____

Responsible Party Information

Name _____ E-mail address _____

Relationship to Patient_____ Address if different from above_____

Cell # _____ Home # _____Work #_____

Employer _____

Orthodontic/Dental Insurance Information

#1 – Name of insured_____ Relationship to patient _____

Date of birth _____Insurance ID# or SS#_____ Ins. Phone #_____

Employer _____ Name of insurance company _____

If patient has additional coverage, please fill in #2.

#2 – Name of insured_____ Relationship to patient_____

Date of birth _____Insurance ID# or SS#_____Ins. Phone #_____

Employer_____ Name of insurance company _____

Health History – Please check any that apply

Asthma	Jaw Joint Pain	AIDS/HIV exposure
Diabetes	Bone Disorders	Heart Condition
Epilepsy	Teeth Grinding	Kidney Problems
Hepatitis	ADD/ADHD	Endocrine Problems
Tuberculosis	Cancer	Pregnant

Physician _____
Allergies_____ Current medications_____
Other conditions that we should know about _____
Have you been informed of any missing/extra teeth? _____
Has an orthodontist previously been consulted? _____
Has there been any previous orthodontic treatment? _____
Please list anything that would make your or your child's experience more comfortable.
_____

_____ _____

Dr.'s Signature **Date** **Signature of Parent/Patient/Guardian** **Date**