



# Darrell Spilsbury, DDS, MS

*Precision orthodontics. Beautiful smiles. Affordably priced.*

731 Mall Ring Circle #100 • Henderson, NV 89014 • Phone: (702) 434-0063 • Fax: (702) 434-0063

## PATIENT INFORMATION

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Birth date \_\_\_\_\_ SS# \_\_\_\_\_

Patient's Dentist \_\_\_\_\_ Oral Surgeon \_\_\_\_\_

List family members currently in our practice \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Email address: \_\_\_\_\_

## RESPONSIBLE PARTY INFORMATION

Patient's Name \_\_\_\_\_  
Last First Middle

Residence \_\_\_\_\_  
Street City State Zip

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_\_) \_\_\_\_\_ Birth date \_\_\_\_\_

SS# \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Email address: \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_ Local # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Insurance Phone # \_\_\_\_\_

## ADDITIONAL INSURANCE INFORMATION

Patient's Name \_\_\_\_\_  
Last First Middle

Residence \_\_\_\_\_  
Street City State Zip

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_\_) \_\_\_\_\_ Birth date \_\_\_\_\_

SS# \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Email address: \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_ Local # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Insurance Phone # \_\_\_\_\_



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## MEDICAL HISTORY

Is patient in good health? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Does patient have any history of major illness? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Has the patient ever been under the care of a physician for illness? Yes \_\_\_\_\_ No \_\_\_\_\_

Please List \_\_\_\_\_

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

Diabetes _____	Tuberculosis _____	Endocrine Problems _____
Pneumonia _____	Anemia _____	Prolonged Bleeding _____
Heart Trouble _____	Epilepsy _____	Fainting & Dizziness _____
Rheumatic Fever _____	Asthma _____	Nervous Disorders _____
Bone Disorders _____	Kidneys _____	Liver _____
High Blood Pr. _____	Hepatitis _____	Venereal Disease _____
Blood Transfusion _____	Emotional Pr. _____	HIV Positive _____
Freq Colds _____	Sore Throats _____	Ear Infections _____

Have tonsils and adenoids been removed? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, at what age? \_\_\_\_\_

List any drugs or medications now being taken. Give Reasons:

<i>Drug</i>	<i>Reason</i>
_____	_____
_____	_____

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

Height \_\_\_\_\_ Weight \_\_\_\_\_ Has the patient reached puberty? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Girls – has she started menstruation? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Boys – has his voice changed? Yes \_\_\_\_\_ No \_\_\_\_\_

## DENTAL HISTORY

Does the patient need to be pre-medicated for dental treatment? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Has there been any injury to the face, mouth or teeth? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Has the patient ever sucked a thumb or fingers? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, until what age? \_\_\_\_\_  
 Does the patient have any speech problems? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Is the patient a mouth breather? While awake? Yes \_\_\_\_\_ No \_\_\_\_\_ While asleep? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Have you been informed of any missing or extra permanent teeth? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Are there any medical, dental, or surgical problems not covered above? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Has an orthodontist been consulted previously? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Has either parent had orthodontic treatment? Yes \_\_\_\_\_ No \_\_\_\_\_

List any musical instruments played: \_\_\_\_\_

Reason for consultation \_\_\_\_\_

## EMERGENCY INFORMATION

Name of nearest relative not living with you \_\_\_\_\_

Complete Address \_\_\_\_\_

Phone # \_\_\_\_\_

Signature (Parent's signature if minor) \_\_\_\_\_ Date \_\_\_\_\_

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

*Please initial*