

WELCOME

TO OUR ORTHODONTIC PRACTICE

The benefits of a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset. Please fill out this form completely. The better we communicate, the better we can care for you.

ABOUT YOU

Today's Date _____

Name: _____
LAST FIRST M MR MRS MS DR

I prefer to be called: _____ Male Female

Birth Date: ___ / ___ / ___ SS# _____

Home Address: _____
APT/CONDO#

CITY STATE ZIP

Single Married Divorced Widowed Separated

Hm#:(____) Cell#:(____)

Wk#:(____) E-mail _____

Employer: _____

Employer's Address: _____

How long there? ___ Occupation: _____

Best place to reach you: _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

General Dentist: _____

Last Visit Date: _____

PRIMARY ORTHODONTIC INSURANCE

Orthodontic Coverage? Yes No Don't Know

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relationship to Patient: _____

Insured's Birth Date: ___ / ___ / ___

Insured's ID# or SS#: _____

Insured's Employer: _____

SECONDARY ORTHODONTIC INSURANCE

Orthodontic Coverage? Yes No Don't Know

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relationship to Patient: _____

Insured's Birth Date: ___ / ___ / ___

Insured's ID# or SS#: _____

Insured's Employer: _____

SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

Wk#:(____) Ext: ___ SS# _____

Birth Date: ___ / ___ / ___

PERSON RESPONSIBLE FOR ACCOUNT (If other than self)

His / Her Name: _____

Wk#:(____) Ext: ___ Hm#:(____)

Cell#:(____)

Billing Address: _____

CITY STATE ZIP

Relation: _____ SS# _____

Employer: _____

IN THE EVENT OF AN EMERGENCY, IS THERE SOMEONE WHO LIVES NEAR YOU THAT WE SHOULD CONTACT?

His / Her Name: _____

Relation: _____

Wk#:(____) Hm#:(____)

MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: _____

Phone#:(____) Date of last visit _____

CONTINUED ON BACK

MEDICAL HISTORY

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain: _____

Are you taking any prescription and/or over-the-counter drugs? Yes No

Please list each one: _____

Have you ever taken Phen-Phen: Yes No
For Women:

Are you taking birth control pills? Yes No

Are you pregnant? (If yes, week#____) Yes No

Are you nursing? Yes No

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

- | | |
|---|------------------------------------|
| Y N Anemia / Radiation Treatment | Y N Heart Surgery / Pacemaker |
| Y N Artificial Bones / Joints | Y N Hemophilia / Abnormal Bleeding |
| Y N Artificial Valves | Y N Hepatitis |
| Y N Asthma / Arthritis | Y N High / Low Blood Pressure |
| Y N Blood Transfusion | Y N HIV+ / AIDS |
| Y N Cancer / Chemotherapy | Y N Hospitalized for Any Reason |
| Y N Congenital Heart Defect | Y N Kidney Problems |
| Y N Diabetes / Tuberculosis (TB) | Y N Mitral Valve Prolapse |
| Y N Difficulty Breathing | Y N Psychiatric Problems |
| Y N Drug / Alcohol Abuse | Y N Rheumatic / Scarlet Fever |
| Y N Emphysema / Glaucoma | Y N Severe / Frequent Headaches |
| Y N Epilepsy / Seizures / Fainting Spells | Y N Shingles |
| Y N Fever Blisters ? Herpes | Y N Sinus Problems |
| Y N Heart Attack / Stroke | Y N Ulcers / Colitis |
| Y N Heart Murmur | Y N Venereal Disease |

Please list any serious medical condition(s) that you have ever had:

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

- | | | |
|-------------------------|------------------------|------------------|
| Y N Aspirin | Y N Dental Anesthetics | Y N Penicillin |
| Y N Any Metal / Plastic | Y N Erythromycin | Y N Tetracycline |
| Y N Codeine | Y N Latex | Y N Other |

Please list any other drugs that you are allergic to: _____

WHAT ARE THE MAIN CONCERNS THAT YOU WOULD LIKE ORTHODONTICS TO ADDRESS?

DENTAL HISTORY

Have you ever had or been evaluated for orthodontic treatment? Yes No

Have you ever had a serious / difficult problem associated with any previous dental work? Yes No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? Yes No

Your current dental health is Good Fair Poor

Do you like your smile? Yes No

Do your gums ever bleed? Yes No

Have you ever had an injury to your Mouth Teeth Chin

Do you have any speech problems? _____

Do you generally breathe through your mouth? Yes No

When awake? Yes No When asleep Yes No

Do you have any missing or extra permanent teeth? Yes No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature _____

Date _____

THANK YOU FOR FILLING OUT THIS FORM COMPLETELY.

This office reserves the right to verify the credit status of potential patients and / or parents of patients prior to extending credit for treatment fees and

Signature _____

Date _____

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein.

Doctors' Comments: _____ Initials: _____ Date: _____

