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ABOUT YOU

Today's Date: _____ E-Mail Address: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ Male Female

Birthdate: _____ Age: _____ SS #: _____

Home Address: _____
APT/CONDO #:

CITY STATE ZIP

Single Married Divorced Widowed Separated

Hm #: (____) _____ Pager / Other #: _____

Wk #: (____) _____ Ext: _____ DL #: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

General Dentist: _____

Last Visit Date: _____

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SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

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

Birthdate: _____

Person Responsible for Account: _____

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

Billing Address: _____

Relation: _____ SS #: _____

Employer: _____ DL #: _____

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ORTHODONTIC INSURANCE

Primary

Orthodontic Coverage: Yes No Dental Coverage: Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

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

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's SS #: _____

Insured's Employer: _____

Secondary

Orthodontic Coverage: Yes No Dental Coverage: Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

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

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's SS #: _____

Insured's Employer: _____

In the event of an emergency, is there someone
who lives near you that we should contact?

His / Her Name: _____ Relation: _____

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

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MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: _____

Phone #: (____) _____ Date of last visit: _____

CONTINUED ON BACK

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MEDICAL HISTORY *continued*

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 / over-the-counter drugs? Yes No

Please list each one: _____

For Women: Are you taking birth control pills? Yes No

Are you pregnant? Yes No Week #: _____

Are you nursing? Yes No

Have you ever had any of the following diseases or medical problems?

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

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

Are you allergic to any of the following?

- | | | |
|---|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Aspirin | <input type="checkbox"/> Y <input type="checkbox"/> N Dental Anesthetics | <input type="checkbox"/> Y <input type="checkbox"/> N Penicillin |
| <input type="checkbox"/> Y <input type="checkbox"/> N Any Metals/Plastics | <input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin | <input type="checkbox"/> Y <input type="checkbox"/> N Tetracycline |
| <input type="checkbox"/> Y <input type="checkbox"/> N Codeine | <input type="checkbox"/> Y <input type="checkbox"/> N Latex | <input type="checkbox"/> Y <input type="checkbox"/> N Other |

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

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DENTAL HISTORY

What are the main concerns that you would like orthodontics to accomplish?

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 Gums ever bleed? Yes No

Have you ever had an injury to your: Mouth Teeth Chin (Check all that apply)

Do you have any speech problems?

Do you generally breathe through your mouth? Yes No
If yes, please check: While Awake? While Asleep?

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

Have you ever taken Phen-Fen? (Also known as Redux or Pondimin) Yes No
If yes, when?

Do you smoke or use tobacco in any form? 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 may, at the discretion of the office, use the services of one or more credit reporting services.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

Signature _____

Date _____

Signature _____

Date _____

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

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I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

