ORTHODONTICS

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Confidential Patient Information

Patient's Name ____ Sex: ❐ Male ❐ Female
Last First Middle

Address ____
Street City State Zip

Home Phone ____________________ Birthdate ________________________ Social Security # __________________

If patient is a minor, give parent's or guardian's name ____

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

Confidential Responsible Party Information

Name ____ Marital Status ____________________
Last First Middle

Residence ____
Street City State Zip

Mailing Address ____
Street City State Zip

Email ____

How long at this address ____________ Home Phone ____________________ Cell Phone ____________________

Previous Address (if less than 3 yrs.) ____
Street City State Zip

Social Security # ________________ Birthdate ________________________ Relationship to Patient ____________

Employer ______________________ Occupation ________________________ No. Years Employed ______________

Spouse's Name ____ Relationship to Patient ____________
Last First Middle

Employer ______________________ Occupation ________________________ No. Years Employed ______________

Social Security # ________________ Birthdate ________________________ Cell Phone ____________________

Insurance Information

Policy Holder's Name ____ Soc. Sec. # ____________________

Insurance Company ____________________________ I.D. Number ______________ Date of Birth __________

Insurance Co. Address ____ Insurance Co. Phone ______________

Policy Holder's Employer ____

Do you have dual coverage? ❐ Y ❐ N If yes:

Policy Holder's Name ____ Soc. Sec. # ____________________

Insurance Company ____________________________ I.D. Number ______________ Date of Birth ____________

Insurance Co. Address ____ Insurance Co. Phone ______________

Policy Holder's Employer ____

Emergency Information

Name of nearest relative not living with you ____

Complete Address ____

Phone ____ Relationship ____

I understand that where appropriate, credit bureau reports may be obtained.
Signature (Parent's signature if minor) ____
Updates (date & initials) ____

(OVER)

Dental History

Why are you interested in orthodontic treatment? ____________________
General Dentist ____________________ Date of last dental care ____________________
Have you ever been evaluated for othodontic treatment? ❐ Y ❐ N
Do you now or have you ever experienced pain or discomfort in your jaw joint? ❐ Y ❐ N
Have you ever experienced a mouth or chin injury? ❐ Y ❐ N
Do you have speech problems?____________________
Do you usually breathe through your mouth while awake? ❐ Y ❐ N Or asleep? ❐ Y ❐ N
Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❐ Y ❐ N
Current or past habits affecting the mouth or teeth: ❐ Thumb sucking ❐ Nail biting ❐ Other ____________________
Other information about your dental health or previous treatment: ____________________

Medical History

Physician's name____________________ Phone____________________
Date of last visit ____________________ Have you ever had any serious illnesses or operations? ❐ Y ❐ N
If yes, describe ____________________
Are you currently under a physician's care? ❐ Y ❐ N If yes, describe ____________________
Have you ever had a blood transfusion? ❐ Y ❐ N If yes, give approximate dates ____________________
Women: Are you pregnant? ❐ Y ❐ N Nursing? ❐ Y ❐ N Taking birth control pills? ❐ Y ❐ N
Check (✔) yes or no to the following:

❐ Y ❐ N AIDS/HIV Positive
❐ Y ❐ N Anaphylaxis
❐ Y ❐ N Anemia
❐ Y ❐ N Arthritis, Rheumatism
❐ Y ❐ N Artificial Heart Valves
❐ Y ❐ N Artificial joints
❐ Y ❐ N Asthma
❐ Y ❐ N Atopic (allergy prone)
❐ Y ❐ N Autism
❐ Y ❐ N Blood disease
❐ Y ❐ N Cancer
❐ Y ❐ N Chemical dependency
❐ Y ❐ N Chemotherapy
❐ Y ❐ N Circulatory problems
❐ Y ❐ N Cortisone treatments
❐ Y ❐ N Cough, persistent
❐ Y ❐ N Cough up blood
❐ Y ❐ N Diabetes
❐ Y ❐ N Epilepsy
❐ Y ❐ N Fainting
❐ Y ❐ N Food allergies
❐ Y ❐ N Glaucoma
❐ Y ❐ N Headaches
❐ Y ❐ N Heart murmur
❐ Y ❐ N Heart problems,
Describe:____________________
❐ Y ❐ N Hemophilia/Abnormal bleeding
❐ Y ❐ N Herpes
❐ Y ❐ N Hepatitis
❐ Y ❐ N High blood pressure
❐ Y ❐ N Jaw pain
❐ Y ❐ N Kidney disease or malfunction
❐ Y ❐ N Liver disease
❐ Y ❐ N Material allergies (latex, wool, metal, chemicals)
❐ Y ❐ N Mitral valve prolapse
❐ Y ❐ N Nervous problems
❐ Y ❐ N Pacemaker/Heart Surgery
❐ Y ❐ N Psychiatric care
❐ Y ❐ N Problems with Back
❐ Y ❐ N Radiation treatment
❐ Y ❐ N Respiratory treatment
❐ Y ❐ N Respiratory disease
❐ Y ❐ N Rapid weight gain or loss
❐ Y ❐ N Shingles
❐ Y ❐ N Shortness of breath
❐ Y ❐ N Sinus problems
❐ Y ❐ N Skin rash
❐ Y ❐ N Spina Bifida
❐ Y ❐ N Stroke
❐ Y ❐ N Surgical implant
❐ Y ❐ N Swelling of feet or ankles
❐ Y ❐ N Thyroid disease or malfunction
❐ Y ❐ N Tobacco habit
❐ Y ❐ N Tonsillitis
❐ Y ❐ N Tuberculosis
❐ Y ❐ N Ulcer/Colitis
❐ Y ❐ N Venereal disease

List medications you are taking, if any:
____
____

List drug allergies, if any:
____
____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the orthodontist to help determine appropriate and healthful orthodontic treatment. If there is any change in my medical status, I will inform the orthodontist.
I authorize the insurance company indicated on this form to pay to the orthodontist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
I authorize the orthdontist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature ____________________ Date____________________

Payment is due in full at time of treatment, unless prior arrangements have been approved.