Welcome to the Orthodontist

Today's Date: ____________________

The benefits of a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset. Our goal is to make everyone's visit pleasant and educational. Please fill out the information below.

Name: ______________________________SS #:__________
LAST FIRST MI MR MRS MS DR

I prefer to be called: ____________ ☐Male ☐Female Birth date: ___/___/_____ Age: ______

Home Address: ______________________________
APT/ CONDO # CITY STATE ZIP

Hm #:__________ Wk #:__________ Ext: ______ DL #:__________ Pager / Other #:__________

☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Employer: ______________________________How long there? __________

Employer's Address: ______________________________

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:__________

Spouse's Name: ______________ SS #:__________Birth date: ___/___/_____

Employer:______________________Wk #:__________Ext:__________

Person Responsible for Account:______________________SS #:__________

Billing Address:______________________________

Relation:__________Wk #:______________Ext:________Hm #:________

Employer:______________________________

ORTHODONTIC INSURANCE – Primary

Orthodontic Coverage: ☐Yes ☐No Insurance Co. Name:______________________

Insurance Co. Address:______________________________

Insurance Co. Phone Number:__________Group # (Plan, Local or Policy #):______________

Insured's Name:______________________ Relation:______________

Insured's Birthdate: ___/___/_____Insured's SS #:______________

Insured's Employer:______________________________

ORTHODONTIC INSURANCE – Secondary

Orthodontic Coverage: ☐Yes ☐No Insurance Co. Name:______________________

Insurance Co. Address:______________________________

Insurance Co. Phone Number:__________Group # (Plan, Local or Policy #):______________

Insured's Name:______________________ Relation:______________

Insured's Birth date: ___/___/_____Insured's SS #:______________

Insured's Employer:______________________________

Emergency Contact Name:______________________________

Relation:__________Wk #:______________Ext:________Hm #:________

(Continue on Back)

MEDICAL HISTORY:

Do you have a personal physician? □Yes □No Date of Last Visit: _______________

Physician Name: ____Phone #:_____________________

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 drug? □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?

Y N Anemia / Radiation Treatment
Y N Cancer/Chemotherapy
Y N Diabetes / Tuberculosis (TB)
Y N Emphysema / Glaucoma
Y N Heart Attack / Stroke
Y N Heart Surgery / Pacemaker
Y N Hepatitis
Y N HIV+ / AIDS
Y N Mitral Valve Prolapse
Y N Sever / Frequent Headaches
Y N Asthma Arthritis
Y N Congenital Heart Defect
Y N Difficulty Breathing
Y N Epilepsy / Seizures / Fainting Spells
Y N Heart Murmur
Y N Hemophilia / Abnormal Bleeding
Y N High / Low Blood Pressure
Y N Kidney Problems
Y N Rheumatic / Scarlet Fever
Y N Sinus Problems

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 Codeine Y N Erythromycin Y N Other
Y N Penicillin Y N Tetracycline Y N Latex

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

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

____

Have you ever 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 you 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? □Yes □No Please explain____

Do you generally breathe through your mouth: □Yes □No Awake? □Yes □No Asleep?

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

- 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.
- I understand that the information 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.

____

Signature Date

Doctor's comments: ____

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