WELCOME TO THE ORTHODONTIST

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.

1 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#:(____)__________________________Cell/Pager#(____)____________________________

WK#:(____)__________________________Ext:______DL#_______________________________

Employer:____

Employer's Address:____

How long there?____________________ Occupation:___________________________________

Where & when are the best times to reach you?_______________________________________

Whom may we Thank for referring you?____

Other family members seen by us?____

General Dentist:____

Date of last visit:____

2 Spouse Information

His/Her Name:____

Employer:____

Wk#:(____)_____________________________ Ext#______ SS#__________________________

Birthdate:_____/_____/_____

Person Responsible For Account:____

Wk#:(____)____________________________Ext#_______ Hm#:(____)____________________

Billing Address:____

Relation:______________________________SS#:__________________________________

Employer:_______________________________________DL#____________________________

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

His/Her Name:________________________________Relation:__________________________

Wk#:(____)__________________________________Hm#:(____)__________________________

3

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 ID#:__________________
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 ID#:__________________
Insured's Employer:______________________________

4

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name:______________________________
Phone#:(____)________________Date of last visit:__________________
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 using a prescribed method of birth control? ☐ 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 Abnormal Bleeding
Y N Anemia
Y N Artificial Bones / Joints / Valves
Y N Asthma / Arthritis
Y N Blood Transfusion
Y N Cancer / Chemotherapy
Y N Hemophilia
Y N Hepatitis
Y N High / Low Blood Pressure
Y N HIV + / AIDS
Y N Hospitalized For Any Reason
Y N Kidney Problems

4 **Medical History** *continued*

Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Drug / Alcohol Abuse
Y N Emphysema
Y N Epilepsy / Seizures / Fainting
Y N Fever Blisters / Herpes
Y N Glaucoma
Y N Heart Attack / Stroke
Y N Heart Murmur
Y N Heart Surgery / Pacemaker
Y N Mitral Valve Prolapse
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic / Scarlet Fever
Y N Severe / Frequent Headaches
Y N Shingles
Y N Sickle Cell Disease / Traits
Y N Sinus Problems
Y N Tuberculosis (TB)
Y N Ulcers / Colitis
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 Any Metal/Plastics
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Latex
Y N Penicillin
Y N Tetracycline
Y N Other

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

____

5 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 (Please Circle)

Do you have any speech problems?____

Do you generally breathe through your mouth? ☐ Yes ☐ No

If yes, please circle: While Awake? While Asleep?

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

5 **Dental History** *continued*

Have you ever taken Fosamax, or any other bisphosphonate?	☐ Yes	☐ No
Have you ever taken Phen-Fen?	☐ Yes	☐ No
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.

Signature Date

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. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office.

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.