

WELCOME TO OUR 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.



Today's Date: ___/___/_____

ABOUT YOU

Email address: _____

Name: _____
LAST _____ FIRST _____ MI _____ MR MRS MS DR

I prefer to be called: _____ Male Female

Birthdate: ___/___/___ Age: _____

Home Address: _____

CITY _____ STATE _____ ZIP _____

Single Widowed Married Divorced Separated

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

Work #: (____) _____ Ext: _____

Best number to reach you: _____

Employer: _____

Occupation: _____

Who may we thank for referring you? _____

General Dentist: _____

Last Visit Date: _____

SPOUSE INFORMATION

His/Her Name: _____

Employer: _____

Work #: (____) _____ Ext: _____

Birthdate: ___/___/_____

Person Responsible For Account: _____

Work #: (____) _____ Ext: _____ Home #: (____) _____

Billing Address: _____

Relation: _____

Employer: _____

ORTHODONTIC INSURANCE

PRIMARY

Ortho Coverage? Yes No Dental Coverage? Yes No

Insured's Name: _____

Insurance Co. Name: _____

Relation: _____ Insured's Birthdate: ___/___/_____

Policy Owners SSN: _____

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

Insured's ID #: _____

Insured's Employer: _____

SECONDARY

Ortho Coverage? Yes No Dental Coverage? Yes No

Insured's Name: _____

Relation: _____ Insured's Birthdate: ___/___/_____

Policy Owners SSN: _____

Insurance Co. Name: _____

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

Insured's ID #: _____

Insured's Employer: _____

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

His/Her Name: _____ Relation: _____

Work #: (____) _____ Ext: _____ Home #: (____) _____

MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: _____

Phone #: (____) _____ Date of Last Visit: _____

Your current physical health: Good Fair Poor

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

Please explain: _____

Are you taking any prescriptions/over-the-counter drugs? Yes No

Please list each one: _____

(Continued on back)

MEDICAL HISTORY CONTINUED

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?

- | | | | |
|---|--------------------------------|---|-----------------------------|
| <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 | Congestive Heart Defect | <input type="checkbox"/> Y <input type="checkbox"/> N | Mitral Valve Problem |
| <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 | Difficult 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/Seisures/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 | Metals/Plastic | <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?

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidences and it is my responsibility to inform this office in any changes in my medical status. I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office.

SIGNATURE

DATE

THANK YOU FOR FILLING OUT THIS FORM COMPLETELY.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

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

Doctor's Comments: _____

DENTAL HISTORY

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

Are you currently consulting any other orthodontic treatments? 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 experiences pain/discomfort in your jaw joint (TMJ/TMD)? Yes No

Your current dental health: Good Fair Poor

Do you like your smile? Yes No

Gums ever bleed? Yes No

Have you ever had an injury to your (please check): Mouth Teeth Chin

Do you have any speech problems? _____

Do you generally breath through your mouth? Yes No

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

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

Have you ever taken Fosamax, or any other bisphosphonate? Yes No

Do you smoke or use tobacco in any form? Yes No