

# 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 #: (\_\_\_\_) \_\_\_\_\_ 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: \_\_\_\_\_

## 2

### 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 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: \_\_\_\_\_

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

His / Her Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Hm #: (\_\_\_\_) \_\_\_\_\_

## 4

### 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 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 Hemophilia
Y N Anemia Hepatitis
Y N Artificial Bones / Joints / Valves High / Low Blood Pressure
Y N Asthma / Arthritis HIV+ / AIDS
Y N Blood Transfusion Hospitalized for Any Reason
Y N Cancer / Chemotherapy Kidney Problems
Y N Congenital Heart Defect Mitral Valve Prolapse
Y N Diabetes Psychiatric Problems
Y N Difficulty Breathing Radiation Treatment
Y N Drug / Alcohol Abuse Rheumatic / Scarlet Fever
Y N Emphysema Severe / Frequent Headaches
Y N Epilepsy / Seizures / Fainting Shingles
Y N Fever Blisters / Herpes Sickle Cell Disease / Traits
Y N Glaucoma Sinus Problems
Y N Heart Attack / Stroke Tuberculosis (TB)
Y N Heart Murmur Ulcers / Colitis
Y N Heart Surgery / Pacemaker 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 Dental Anesthetics Penicillin
Y N Any Metals/Plastics Erythromycin Tetracycline
Y N Codeine Latex 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 (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

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.

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

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.

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: