VANLAECKEN ORTHODONTICS

Beautiful, Confident Smiles™

WHAT HELPED YOU DECIDE TO COME TO VANLAECKEN ORTHODONTICS?

◯ OFFICE STAFF ◯ DENTIST ◯ FAMILY/FRIENDS

REFERRER'S NAME (IF APPLICABLE) _____

◯ SIGNAGE ◯ WEBSITE/INTERNET ◯ RADIO

◯ SCHOOL ◯ FACEBOOK ◯ YELLOW PAGES

◯ INVISALIGN PROVIDER LIST ◯ PROMOTION/ DIRECT MAILING ◯ SPORT TEAM/ SPONSORSHIP

◯ INSURANCE PROVIDER LIST ◯ HEALTHGRADES PAGE ◯ OTHER (SPECIFY) _____

PATIENT INFORMATION

TODAY'S DATE _____ ◯ MALE ◯ FEMALE

PATIENT'S NAME (FIRST AND LAST) _____

PATIENT PREFERRED NAME _____

BIRTH DATE _____

SCHOOL NAME _____

EMAIL _____

ADDRESS _____

_____ CITY _____

STATE _____ ZIP CODE _____

SSN# _____

HOME PHONE _____

CELL PHONE _____

DENTIST _____

PREFERRED LOCATION

◯ ABERDEEN ◯ BROOKINGS ◯ MILBANK

◯ SIOUX FALLS ◯ WATERTOWN

PLEASE FILL OUT IF PATIENT IS UNDER 18

WHO IS ACCOMPANYING THE PATIENT TODAY?

NAME _____

RELATIONSHIP TO PATIENT _____

DO YOU HAVE LEGAL CUSTODY OF THIS PATIENT? ◯ YES ◯ NO

MOTHER'S INFORMATION

◯ MOTHER ◯ STEPMOTHER ◯ GUARDIAN

NAME _____ BIRTH DATE _____

HOME PHONE _____

CELL PHONE _____

ADDRESS _____

_____ CITY _____

STATE _____ ZIP CODE _____

EMAIL _____

SSN# _____

FATHER'S INFORMATION

◯ FATHER ◯ STEPFATHER ◯ GUARDIAN

NAME _____ BIRTHDATE _____

HOME PHONE _____

CELL PHONE _____

ADDRESS _____

_____ CITY _____

STATE _____ ZIP CODE _____

EMAIL _____

SSN# _____

PARENTS' MARITAL STATUS

◯ SINGLE ◯ MARRIED ◯ SEPARATED

◯ WIDOWED ◯ DIVORCED

WHO IS RESPONSIBLE FOR THE ACCOUNT?

NAME _____

RELATIONSHIP TO PATIENT _____

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INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

INSURANCE COMPANY NAME _____

INSURANCE COMPANY PHONE _____

POLICY HOLDER'S NAME _____

POLICY HOLDER'S SSN# _____

GROUP NUMBER _____

INSURANCE ID NUMBER _____

POLICY HOLDER'S BIRTHDATE _____

POLICY HOLDER'S EMPLOYER _____

RELATIONSHIP TO PATIENT _____

SECONDARY DENTAL INSURANCE

INSURANCE COMPANY NAME _____

INSURANCE COMPANY PHONE _____

POLICY HOLDER'S NAME _____

POLICY HOLDER'S SSN# _____

GROUP NUMBER _____

INSURANCE ID NUMBER _____

POLICY HOLDER'S BIRTHDATE _____

POLICY HOLDER'S EMPLOYER _____

RELATIONSHIP TO PATIENT _____

INSURANCE CONSENT

I hereby authorize the release of information relating to this and future insurance claims (including the addition of insurance at a later date). I agree to the assignment of insurance benefits to VanLaecken Orthodontics.

SIGNATURE _____
(PARENT/GUARDIAN SIGNATURE IF MINOR)

CONSENT TO INITIAL ORTHODONTIC EXAM

I (we) understand that by signing this, I(we) are providing our consent to VanLaecken Orthodontics and its staff and personnel to conduct an initial Orthodontic Examination for above patient.

◯ AGREE

SIGNATURE _____
(PARENT/GUARDIAN SIGNATURE IF MINOR)

HIPAA PRIVACY ACT ACKNOWLEDGEMENT

I hereby acknowledge that I have received and reviewed a copy of VanLaecken Orthodontics Privacy Notice (A copy is available for you viewing on our website).

◯ AGREE

SIGNATURE _____
(PARENT/GUARDIAN SIGNATURE IF MINOR)

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MEDICAL HISTORY

IS IT NECESSARY TO PRE-MEDICATE PATIENT BEFORE APPOINTMENT? ◯ YES ◯ NO

IS THE PATIENT UNDER THE CARE OF A PHYSICIAN NOW? ◯ YES ◯ NO

NAME OF PHYSICIAN: _____

IF SO, WHAT CONDITION: _____

MEDICATIONS
(LIST ALL MEDICATIONS THE PATIENT IS CURRENTLY TAKING OR HAS TAKEN IN THE LAST SIX MONTHS INCLUDING HEART OR BLOOD PRESSURE, CORTISONE, ANTICANCER, ANTIFUNGAL, ANTIBIOTIC, BIRTH CONTROL, OSTEOPOROSIS/BONE LOSS TREATMENT OR MEDICATIONS)

_____

_____

VIRAL INFECTION
(LIST PAST AND CURRENT VIRAL INFECTIONS INCLUDING HERPES SIMPLEX, MONONUCLEOSIS, SHINGLES, HEPATITIS, AIDS, COVID-19)

_____

_____

HOSPITALIZATIONS
(PLEASE LIST ALL)

_____

_____

ALLERGIES TO FOOD? ◯ YES ◯ NO

IF YES, EXPLAIN: _____

SEASONAL ALLERGIES? ◯ YES ◯ NO

IF YES, EXPLAIN: _____

ALLERGIES TO DRUGS? ◯ YES ◯ NO
(IE. PENICILLIN, LOCAL ANESTHETICS)

IF YES, EXPLAIN: _____

ALLERGIES TO OTHER THINGS? ◯ YES ◯ NO
(IE. NICKEL, LATEX)

IF YES, EXPLAIN: _____

ARE THERE ANY OTHER CONDITIONS, SYNDROMES OR HEALTH ISSUES NOT LISTED? ◯ YES ◯ NO

IF YES, EXPLAIN: _____

_____

HAS THE PATIENT RECEIVED MEDICAL TREATMENT FROM AN ALLERGIST OR EAR, NOSE & THROAT SPECIALIST? ◯ YES ◯ NO

IF YES, EXPLAIN: _____

IS THE PATIENT PREGNANT? ◯ YES ◯ NO

IF YES, WHAT IS THE DUE DATE: _____

DOES THE PATIENT USE TOBACCO PRODUCTS? ◯ YES ◯ NO

IF YES, APPROXIMATE FREQUENCY: _____

IF YES, APPROXIMATE QUANTITY: _____

DOES THE PATIENT CURRENTLY HAVE, OR HAS EVER HAD ANY OF THE FOLLOWING? (SELECT ALL THAT APPLY)

- ◯ ADD/ADHD
- ◯ AIDS/HIV POSITIVE
- ◯ ALCOHOLISM/ DRUG ADDICTION
- ◯ ANEMIA
- ◯ ARTHRITIS
- ◯ ASTHMA
- ◯ BONE DISORDER/ BISPHOSPHONATE/ OSTEOPOROSIS
- ◯ BRUISES OR BLEED EASILY
- ◯ CANCER OR TUMOR
- ◯ CANCER THERAPY
- ◯ DIABETES
- ◯ DISABILITY (MENTAL)
- ◯ DISABILITY (PHYSICAL)
- ◯ EAR INFECTION
- ◯ EPILEPSY/CONVULSIONS/ SEIZURES
- ◯ FAINTING OR DIZZINESS
- ◯ FREQUENT COLDS
- ◯ FREQUENT SORE THROAT
- ◯ FREQUENT STUFFY NOSE
- ◯ GLAUCOMA
- ◯ HEART MURMUR/MVP
- ◯ HEART PROBLEMS
- ◯ HEMODIALYSIS
- ◯ HEMOPHILIA/ PROLONGED BLEEDING
- ◯ HIGH BLOOD PRESSURE
- ◯ IMPAIRED HEARING
- ◯ INJECTIONS OTHER THAN DENTAL OR TETANUS
  IF YES, DATE: _____
- ◯ JOINT REPLACEMENT
- ◯ KIDNEY DISEASE
- ◯ LIVER DISEASE
- ◯ MRSA/MRSA CARRIER
- ◯ NASAL SURGERY
  IF YES, DATE: _____
- ◯ NERVOUS DISORDERS
- ◯ PAINFUL JOINTS
- ◯ PSYCHIATRIC TREATMENT
- ◯ REPOSITORY DISEASE
- ◯ RHEUMATIC FEVER
- ◯ SINUS PROBLEMS
- ◯ SLEEP APNEA
- ◯ STROKE
- ◯ THYROID PROBLEMS
- ◯ TRANSFUSIONS
  IF YES, DATE: _____
- ◯ TUBERCULOSIS/ POSITIVE PPD
- ◯ ULCERS
- ◯ NONE OF THE ABOVE

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DENTAL HISTORY

HAS THE PATIENT HAD A CLEANING & DENTAL EXAM WITHIN THE LAST 6 MONTHS? ◯ YES ◯ NO

IF YES, WHEN? _____

HAS THE PATIENT HAD ANY UNUSUAL DENTAL EXPERIENCES? ◯ YES ◯ NO

IF YES, DESCRIBE: _____

HAS THE PATIENT HAD ANY INJURIES TO THE MOUTH, TEETH OR JAW? ◯ YES ◯ NO

IF YES, DESCRIBE: _____

HAS THE PATIENT EVER RECEIVED A SEVERE BLOW TO THE JAW? ◯ YES ◯ NO

HAS ANYONE ELSE IN THE PATIENT'S FAMILY HAD ORTHODONTIC TREATMENT? ◯ YES ◯ NO

HAS THE PATIENT HAD AN ORTHODONTIC CONSULT OR TREATMENT? ◯ YES ◯ NO

IF YES, LIST DATE & WITH WHOM: _____

IS THE PATIENT ADOPTED? ◯ YES ◯ NO

IF NOT ADOPTED, WHO DOES THE PATIENT LOOK MOST LIKE?

◯ MOTHER
◯ FATHER

ORTHODONTIC GROWTH PATTERNS ARE OFTEN INHERITED, AND KNOWING WHO THE CHILD FAVORS CAN HELP THE ORTHODONTIST BETTER CUSTOMIZE SUCCESSFUL TREATMENT OPTIONS.

DOES THE PATIENT HAVE:

◯ EAR PAIN ◯ EYE PAIN ◯ FACE PAIN
◯ HEADACHES ◯ JAW PAIN ◯ NECK PAIN
◯ OTHER (SPECIFY) _____

DOES THE PATIENT'S JAW EVER MAKE:

◯ A POPPING NOISE ◯ CLICKING
◯ GRINDING ◯ OTHER (SPECIFY) _____

DOES THE PATIENT EVER CLENCH OR GRIND HIS/HER TEETH? ◯ YES ◯ NO

IF YES, WHEN? _____

HAS THE PATIENT'S JAW EVER LOCKED UP OR SLIPPED OUT OF PLACE? ◯ YES ◯ NO

DOES THE PATIENT HAVE PROBLEMS WITH HIS/HER:

◯ EARS ◯ HEARING
◯ DIZZINESS ◯ OTHER (SPECIFY) _____

IS IT DIFFICULT TO SWALLOW? ◯ YES ◯ NO

ARE THE TEETH SORE OR SENSITIVE? ◯ YES ◯ NO

DOES THE PATIENT EXHIBIT THUMB OR FINGER SUCKING? ◯ YES ◯ NO

DOES THE PATIENT EXHIBIT TONGUE THRUST (REVERSE SWALLOWING)? ◯ YES ◯ NO

DOES THE PATIENT EXHIBIT LIP BITING? ◯ YES ◯ NO

DOES THE PATIENT EXHIBIT NAIL BITING? ◯ YES ◯ NO

DOES THE PATIENT EXHIBIT POOR SPEECH HABITS? ◯ YES ◯ NO

DOES THE PATIENT EXHIBIT ANY OTHER HABITS LIKE THE ABOVE? ◯ YES ◯ NO

IF YES, DESCRIBE: _____

DOES THE PATIENT EXHIBIT ANY OF THE FOLLOWING:

◯ CAVITIES (PRESENT) ◯ EXTRA PERMANENT TEETH
◯ FACIAL/DENTAL PAIN ◯ DIFFICULTY BREATHING THROUGH NOSE
◯ MISSING PERMANENT TEETH
◯ MOUTH BREATHING ◯ SNORING DURING SLEEP
◯ TONSIL/ADENOID PROBLEMS ◯ NONE OF THE ABOVE

DOES THE PATIENT WANT HIS/HER TEETH STRAIGHTENED? ◯ YES ◯ NO

WHAT IS THE PATIENT MOST CONCERNED ABOUT?

◯ BITE ◯ APPEARANCE
◯ FACIAL PROFILE ◯ OTHER (SPECIFY) _____