

Welcome

TO THE ORTHODONTIST

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: _____

Name: _____ ☐ M ☐ F
LAST FIRST MI

Birthdate: ____/____/____ Age: ____ SS#: _____

Home Address: _____

CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

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

Wk #: (____) _____ DL #: _____

E-Mail Address: _____

Employer: _____

Employer's Address: _____

CITY STATE ZIP

How long there? _____ Occupation: _____

When are best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

General Dentist: _____

Previous or Present (Please circle) Date of last visit: _____

3

Orthodontic Insurance

Primary

Orthodontic Coverage: ☐ Y ☐ N Dental Coverage: ☐ Y ☐ N

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: ☐ Y ☐ N Dental Coverage: ☐ Y ☐ N

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: _____

2

Spouse Information

His/Her Name: _____

Employer: _____

Wk #: (____) _____ Ext: _____

Birthdate: ____/____/____ SS #: _____

In the event of an emergency, whom should we contact?

His/Her Name: _____

Relationship: _____

Wk #: (____) _____ Hm #: (____) _____

4

Medical History

Do you currently have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Ph #: (____) _____ Date of last visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Person Responsible for Account: _____

Wk #: (____) _____ Hm #: (____) _____

Billing Address: _____

Relation: _____ SS #: _____

Employer: _____ DL #: _____

4

Medical History cont.Are you currently under the care of a physician? ☐ Y ☐ N

Please explain: _____

Are you taking any prescriptions /over-the-counter drugs? ☐ Y ☐ N

Please list each one: _____

WOMEN: Are you using a prescribed method of birth control? ☐ Y ☐ NAre you pregnant? ☐ Y ☐ N Week #: _____Are you nursing? ☐ Y ☐ N

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 Heart Surgery / Pacemaker |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones / Joints / Valves | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis | <input type="checkbox"/> Y <input type="checkbox"/> N High / Low Blood Pressure |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <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 Congenital Heart Defect | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse |
| <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 Difficulty 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 Shingles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy / Seizures / Fainting | <input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Disease / Traits |
| <input type="checkbox"/> Y <input type="checkbox"/> N Fever Blisters / Herpes | <input type="checkbox"/> Y <input type="checkbox"/> N Sinus Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Frequent / Severe Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke |
| <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB) |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcers / Colitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur | <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 Codeine | <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 Metals / Plastics | <input type="checkbox"/> Y <input type="checkbox"/> N Latex | <input type="checkbox"/> Y <input type="checkbox"/> N Other |

Please list any other drug/ material allergies: _____

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Dental History

What would you like orthodontics to accomplish?

Have you ever had or been evaluated for orthodontic treatment? ☐ Y ☐ NHave you ever had a serious / difficult problem associated with any previous dental work? ☐ Y ☐ NDo you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Y ☐ NYour current dental health is: ☐ Good ☐ Fair ☐ PoorDo you like your smile? ☐ Y ☐ N Do your gums bleed? ☐ Y ☐ NHave you ever had an injury to your: ☐ Mouth ☐ Teeth ☐ Chin

Indicate any speech problems _____

Do you breathe through your mouth? ☐ While Awake ☐ While AsleepDo you have any missing or extra permanent teeth? ☐ Y ☐ NHave you ever taken Fosamax or any other bisphosphonate? ☐ Y ☐ NHave you ever taken Phen-Fen? ☐ Y ☐ NDo you smoke or use tobacco in any form? ☐ Y ☐ N

I

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

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

Doctor's Comments: _____
