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 #:_____

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:_____

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

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

Do you have any speech problems? _____

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

If yes, please check: ☐ 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

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.

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

Doctor's Comments: _____

_____

_____

_____

_____