WELCOME

TO OUR ORTHODONTIC PRACTICE

Thank you for choosing our orthodontic team! We will strive to provide you with the best possible care. To help us meet all your orthodontic needs, please fill out this form completely.

Patient Information (CONFIDENTIAL)

Today's Date:__________

Patient's Name:____________________ ☐ Male ☐ Female Birth date:__________

Address:____________________ City:__________ State:_____ Zip:_____

Home phone:_______________ Cell Phone:_______________

If Student, Name of School or College? ☐ Full time ☐ Part Time

Whom may we thank for referring you?____________________

General Dentist Name:_______________ Last Visit Date:__________

Hobbies / Sports?_______________ Other family members seen by us:__________

Responsible Party

Full Name:____________________ Relationship to Patient:__________

Billing Address:_______________ City:__________ State:_____ Zip:_____

Home Phone:__________ Work Phone__________ Cell Phone:__________

Social Security #:_______________ Birth date:__________

Employer:_______________ How Long at Current Job:__________ Job Title:__________

Insurance Information

Orthodontic Coverage? ☐ Yes ☐ No ☐ Don't Know

Name of Insured:____________________ Relationship to Patient:__________

Birth date:__________ Social Security #:__________ Member ID #__________

Group #__________ Insurance Company Name:_______________

Insurance Company Phone #:__________ Ins. Co. Address:_______________

Employer:_______________ Life Time Maximum?__________

Secondary Insurance

Name of Insured:____________________ Relationship to Patient:__________

Birth date:__________ Social Security #:__________ Member ID #__________

Group#__________ Insurance Company Name:_______________

Insurance Company Phone #__________ Ins. Co. Address:_______________

Employer:_______________ Life Time Maximum?__________

Over Please

Patient Medical History

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

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

If yes, please explain____

____

Are you taking any medications? Including non-prescription medication? If yes, please list all that you are taking:______

____

Do you use tobacco? ☐ Yes ☐ No

Has puberty begun? ☐ Yes ☐ No

Women Only:

Has menstruation begun? ☐ Yes ☐ No

Are you pregnant or think you might be pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Are you taking oral contraceptives? ☐ Yes ☐ No

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Aspirin	Y N	Dental Anesthetics	Y N
Any Metals	Y N	Plastics	Y N
Codeine	Y N	Rubber/Latex	Y N
Penicillin	Y N	Other	Y N

List any known alleries other than above:__________

____

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Y N Anemia / Radiation Treatment	Y N Heart Surgery / Pacemaker
Y N Artificial Bones / Joints	Y N Hemophilia / Abnormal Bleeding
Y N Artificial Valves	Y N Hepatitis
Y N Asthma / Arthritis	Y N High / Low Blood Pressure
Y N Blood Transfusion	Y N HIV+ / AIDS
Y N Cancer / Chemotherapy	Y N Hospitalized for any reason?
Y N Congenital Heart Defect	Y N Kidney Problems
Y N Tuberculosis (TB)	Y N Mitral Valve Prolapse
Y N Difficulty Breathing	Y N Psychiatric Problems
Y N Drug / Alcohol Abuse	Y N Rheumatic / Scarlet Fever
Y N Emphysema / Glaucoma	Y N Severe / Frequent Headaches
Y N Epilepsy / Seizures / Fainting Spells	Y N Diabetes
Y N Fever Blisters / Herpes	Y N Sinus Problems
Y N Heart Attack / Stroke	Y N Ulcers / Colitis
Y N Heart Murmur	Y N Venereal Disease

For office use only

Please list any serious medical condition (s) that you have ever had:______________________________

DENTAL HISTORY

Are your teeth sensitive to hot and cold?	☐ Yes ☐ No
Do you feel pain in any of your teeth?	☐ Yes ☐ No
Any popping, clicking, or pain in your jaws?	☐ Yes ☐ No
Do you clench or grind your teeth?	☐ Yes ☐ No
Is the patient happy with their "Smile"?	☐ Yes ☐ No

I understand the information is correct and will be in the strictest confidence and that it is my responsibility to inform this office of any changes in the patient's medical status.

______________________________ Parent's Signature

____/____/____ Date