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 (CONFIDENTAL) **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: _______
Cell Phone: _______________ Work Phone: ____________ Date of Birth: __________________
Employer: __________________________ How long at current job: ______________________
Email address: ___________________________________ 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 Co Name: ____
Insurance Co Phone # _____________________ Ins Co Address: ___________________________
Employer: ______________________________ Life Time Max? _____________________________

Over please

Patient Medical History

Your current physical health is: □ Good □ Fair □ Poor
Are 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 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 allergies other than above:__________

____

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

		For office use only
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 Desease	______

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

DENTAL HISTORY

Does the patient need antibiotics before dental cleanings?	□ Yes □ No
Are your teeth sensitive to hot or 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 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 is my responsibility to inform this office of any changes in my/my child's medical status. I authorize the dental staff to perform any necessary dental service that I/my child may need during diagnosis and treatment. I also authorize the orthodontist to share patient's treatment information with collaborating dentist and surgeons when appropriate. I also authorize the orthodontist to submit treatment information pertinent to this patient to the insurance company for billing purposes.

______________________________   _____/_____/_____
Parent's/Guardian Signature   Date