______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

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:____________

____

Women Only:

Are you pregnant or think you might be pregnant? □ Yes □ No
Are you taking oral contraceptives? □ Yes □ No

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 Disease	____________________

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

DENTAL HISTORY

Does the patient need antibiotics before dental cleanings/work?	□ 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.

____   _____/_____/____

Patient's Signature   Date