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

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:_____
_____

Women Only:
Are you pregnant or think you might be pregnant? ☐ Yes ☐ No
Are you nursing? ☐ 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

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.

_____ ____/____/____
Patient's Signature Date