Welcome To Our Office

So that we might become better acquainted please complete <u>both</u> sides of this form.

Patient Information

Patient's Name: _____ Preferred Name: _____ Sex: _____

Home Address: _____ City: _____ Zip: _____

Home Phone: _____ Age: _____ Birthdate: _____ School: _____ Grade: _____

Employed By: _____ Bus. Address: _____

Occupation: _____ _____

Social Security No.: _____ Bus. Phone: _____ Ext. _____

Are you ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Name of Spouse: _____ Birthdate: _____

Employed By: _____ Bus. Address: _____

Occupation: _____ _____

Social Security No.: _____ Bus. Phone: _____ Ext. _____

Names and ages of children in family: _____

If you are completing this form for another person what is your relationship to that person? _____

Please describe your orthodontic problem in your words: _____

_____

Has any member of the patient's family undergone orthodontic treatment? _____

Whom may we thank for referring you to our office? _____

Person responsible for account: _____

If other than parent:
Name: _____ Address: _____ Phone: _____

Insurance Information

A dental insurance policy is a contract between the insured and the insurance company. Our professional services are rendered and charged directly to the patient's account and the patient or person responsible for payment of all fees incurred. For you convenience, we will gladly assist you in submitting insurance claims pertaining to any charge for care in our office. If you wish assistance, please let us know and we will provide you with the necessary orthodontic insurance forms. Otherwise, we will assume you are submitting all claims to your insurance carrier.

Name of insured (Employee): _____ Date of Birth: _____

Name of insurance company: _____ Group #: _____

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Your answers to the following questions will be helpful in selecting the safest and most effective means of providing you with orthodontic care. All information will be kept completely confidential.

Medical History

Physician's Name: _____ Address: _____ Phone: _____

Have you experienced any health problems?	☐ No	☐ Yes	Explain: _____
Any major change in your health recently?	☐ No	☐ Yes	Explain: _____
Are you currently under a physician's care?	☐ No	☐ Yes	Explain: _____
Are you currently taking medications?	☐ No	☐ Yes	Explain: _____
Are you allergic to any medications?	☐ No	☐ Yes	Explain: _____
Have you received a blood transfusion?	☐ No	☐ Yes	Explain: _____
Have your tonsils or adenoids been removed?	☐ No	☐ Yes	Explain: _____
Have you been in a risk group for AIDS?	☐ No	☐ Yes	Explain: _____
Have you been on Phen-Fen or Redux?	☐ No	☐ Yes	Explain: _____

Please check if you have any of the following conditions:

Heart Murmur	☐ No ☐ Yes	Hepatitis	☐ No ☐ Yes	Emotional Problems	☐ No ☐ Yes
Heart Surgery	☐ No ☐ Yes	Diabetes	☐ No ☐ Yes	Frequent Headaches	☐ No ☐ Yes
Rheumatic Fever	☐ No ☐ Yes	Kidney Disease	☐ No ☐ Yes	Nervous/Anxious	☐ No ☐ Yes
Endocrine Disorders	☐ No ☐ Yes	Liver Disease	☐ No ☐ Yes	Cancer	☐ No ☐ Yes
Prolonged Bleeding	☐ No ☐ Yes	Tuberculosis	☐ No ☐ Yes	Bone Disorders	☐ No ☐ Yes
Anemia	☐ No ☐ Yes	Bronchitis	☐ No ☐ Yes	Growth Disorders	☐ No ☐ Yes
Blood Disease	☐ No ☐ Yes	Asthma	☐ No ☐ Yes	Mouth Breather	☐ No ☐ Yes
Developmental Disorder	☐ No ☐ Yes	Epilepsy	☐ No ☐ Yes	Herpes (Fever Blisters)	☐ No ☐ Yes
Hives/Rash	☐ No ☐ Yes	Fainting	☐ No ☐ Yes	Tonsillitis	☐ No ☐ Yes

Is there any other condition or problem that you think we should know about? _____

Comments: _____

_____

Dental History

Dentist's Name: _____ Address: _____ Phone: _____

Frequency of dental checks: ☐ Twice a year ☐ Once a year ☐ Only if a problem exists ☐ Never Date of last visit: _____

Is there any unfinished care to be completed with your dentist?	☐ No ☐ Yes	Explain: _____
Are you frightened about dental treatment?	☐ No ☐ Yes	Explain: _____
Have you had an unpleasant experience in a dental office?	☐ No ☐ Yes	Explain: _____
Have you had any facial or dental injuries?	☐ No ☐ Yes	Explain: _____
Is there any history of thumb or finger sucking?	☐ No ☐ Yes	Stopped? _____
Do you play a musical instrument?	☐ No ☐ Yes	What instrument? _____
Have you consulted an orthodontist previously?	☐ No ☐ Yes	With whom? _____
Have teeth (either primary or permanent) been removed?		
Have you had any previous orthodontic treatment?	☐ No ☐ Yes	With whom? _____
Are you satisfied with prior treatment?	☐ No ☐ Yes	Explain: _____

Please check if there is any history of:

☐ Clenching teeth ☐ Muscular soreness around head and neck ☐ Jaw joint popping

☐ Grinding teeth ☐ Headaches (more than normal) ☐ Jaw joint clicking

☐ Ringing in the ears ☐ Jaw joint soreness

☐ Speech problems (which sounds _____) ☐ Mouth breathing: Awake_____ Asleep_____

Is there any other information that may be helpful? _____

_____

_____

Patient's Signature Date Reviewed by: