

# Welcome to the Orthodontist

Please fill out this form completely, it is important to your dental care. Our goal is to help you reach and maintain good oral health.

## About You

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ ☐ M ☐ F

Last First MI

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ SS #: \_\_\_\_\_

Home Address: \_\_\_\_\_

City State Zip

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (\_\_\_\_) Cell #: (\_\_\_\_)

Wk #: (\_\_\_\_) DL #: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City State Zip

How long there? \_\_\_\_\_ Occupation: \_\_\_\_\_

What time is best to reach you? \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Other family members seen by us: \_\_\_\_\_

Dentist Name: \_\_\_\_\_

Previous or Present (Please Circle) Date of last visit? \_\_\_\_\_

Person Responsible for Account: \_\_\_\_\_

## Orthodontic Insurance

### PRIMARY

Orthodontic Coverage? ☐ Y ☐ N Dental Coverage? ☐ Y ☐ N

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

City State Zip

Insurance Co. Phone #: (\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's ID #: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City State Zip

### SECONDARY

Orthodontic Coverage? ☐ Y ☐ N Dental Coverage? ☐ Y ☐ N

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

City State Zip

Insurance Co. Phone #: (\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's ID #: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City State Zip

## Spouse Information

His/Her Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Wk #: (\_\_\_\_) SS #: \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ DL #: \_\_\_\_\_

Relative or friend not living with you.

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Wk #: (\_\_\_\_) Hm #: (\_\_\_\_)

**Payment is due in full at the time of treatment unless prior arrangements have been approved.**

If this office accepts insurance, I understand that I am responsible for payment of services rendered and for paying any co-payment that my insurance does not cover, including the deductible. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

SIGNATURE

DATE

Continued on Back



## Medical History

Do you have a personal physician? ☐ Y ☐ N

Physician's Name: \_\_\_\_\_

Ph #: (\_\_\_\_) \_\_\_\_\_ Date of last visit: \_\_\_\_\_

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

Are you currently under the care of a physician? ☐ Y ☐ N

Please explain: \_\_\_\_\_

Do you smoke or use tobacco in any other form? ☐ Y ☐ N

Have you had any metal rods, pins or implants? ☐ Y ☐ N

Are you taking any prescription/over-the-counter drugs? ☐ Y ☐ N

Please list each one: \_\_\_\_\_

Have you ever taken Fosamax or any bisphosphonate? ☐ Y ☐ N

Have you ever taken Phen-Fen (Redux or Pondimin)? ☐ Y ☐ N

If so, when? \_\_\_\_\_

**WOMEN:** Are you taking birth control pills? ☐ Y ☐ N

Are you pregnant? ☐ Y ☐ N Week #: \_\_\_\_\_

Are you nursing? ☐ Y ☐ N

Have you ever had any of the following diseases or medical problems

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

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

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Penicillin
Y N Codeine	Y N Jewelry/Metals	Y N Tetracycline
Y N Dental Anesthetics	Y N Latex	Y N Other

List any other drugs/material allergies: \_\_\_\_\_

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

## Medical History Update

Has there been any change in your health status since your last visit? Y N

If Yes, please explain \_\_\_\_\_

Has there been any change in your health status since your last visit? Y N

If Yes, please explain \_\_\_\_\_

## Dental History

What would you like orthodontics to accomplish?

Have you ever had or been evaluated for orthodontic treatment? ☐ Y ☐ N

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Y ☐ N

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Y ☐ N

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

Do you still have wisdom teeth? ☐ Y ☐ N

Have you ever had an injury to your: ☐ Mouth ☐ Teeth ☐ Chin

Do you have any speech problems? ☐ Y ☐ N

Do you breathe through your mouth? ☐ While Awake ☐ While Asleep

Do you have any missing or extra permanent teeth? ☐ Y ☐ N

Do you like your smile? ☐ Y ☐ N

If not, what would you change? \_\_\_\_\_

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 that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

SIGNATURE

DATE

## Office Use Only

I verbally reviewed the medical/dental information with the patient named herein.

Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient Signature

Date

Doctor Signature

Date

Patient Signature

Date

Doctor Signature

Date