Welcome to the Orthodontist

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The benefits of a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset.
Please fill out the forms completely. The better we communicate, the better we can care for you.

1 About You

Todays Date: ______________________________

Name: ______________________________
Last First MI Mr. Mrs. Ms. Dr.

I preferred to be called: ______________________________

Birthdate: __________ Age: __________ SS #: ______________

Home Address: ______________________________

____
City State Zip

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home #: ____________ Pager / Other: ______________

Wk#: ______________ Ext _____ DL #: ______________

Employer: ______________________________

Employer's Address: ______________________________

How Long There? __________ Occupation: ______________

Where & When are best times to reach you? ______________

Whom may we Thank for referring you? ______________

Other family members seen by us: ______________

General Dentist: ______________________________

Last Visit Date: ______________________________

2 Spouse Information

His / Her Name: ______________________________

Employer: ______________________________

Work #: ______________ Ext. _____ SS #: ______________

Birthdate: ______________________________

Email: ______________________________

Person Responsible for Account: ______________

Work #: __________ Ext: _____ Home #: ______________

Billing Address: ______________________________

Relationship: ______________ SS #: ______________

Employer: ______________ DL #: ______________

Email: ______________________________

3 Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: ______________________________

Insurance Co. Address: ______________________________

Insurance Co. Phone #: ______________________________

Group # (Plan, Local, Policy #): ______________

Insured's Name: ______________________________

Relationship to Patient: ______________________________

Insured's Birthday: ______________ & SS #: ______________

Insured's Employer: ______________________________

Secondary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: ______________________________

Insurance Co. Address: ______________________________

Insurance Co. Phone #: ______________________________

Group # (Plan, Local, Policy #): ______________

Insured's Name: ______________________________

Relationship to Patient: ______________________________

Insured's Birthday: ______________ & SS #: ______________

Insured's Employer: ______________________________

In the event of an emergency, is there someone who lives near you that we should contact?

Their Name: ______________________________

Relation: ______________________________

Wk #: ______________ Home #: ______________

4 Medical History

Do you have a personal physician? ❑ No ❑ Yes

Physician's Name: ______________________________

Phone #: ______________________________

Your current physical health is ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ No ❑ Yes

Please explain ______________________________

Continued

4 MEDICAL HISTORY CONTINUED

Are you taking any prescription / over-the-counter drugs? ❏ No ❏ Yes

Pleas list each one ____

____

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

Y	N	Heart Attack / Stroke	Y	N	Psychiatric Problems
Y	N	Cancer / Chemotherapy	Y	N	Epilepsy / Seizures / Fainting Spells
Y	N	Heart Murmur	Y	N	Diabetes / Tuberculosis (TB)
Y	N	Rheumatic Fever	Y	N	Drug / Alcohol Abuse
Y	N	HIV + / Aids	Y	N	Venereal Disease
Y	N	Heart surgery / Pacemaker	Y	N	Hemophilia / Abnormal Bleeding
Y	N	Shingles	Y	N	Ulcer / Colitis
Y	N	Mitral Valve Prolapse	Y	N	Congenital Heart Defect
Y	N	Kidney Problems	Y	N	Anemia / Radiation Treatment
Y	N	Artificial Bones / Joints	Y	N	Asthma / Arthritis
Y	N	Artificial Valves	Y	N	Difficulty Breathing
Y	N	Sinus Problems	Y	N	Hospitalized for Any Reason
Y	N	High / Low Blood Pressure	Y	N	Hepatitis
Y	N	Fever Blisters	Y	N	Blood Transfusion
Y	N	Severe/ Frequent Headaches	Y	N	Emphysema / Glaucoma

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

____

Are you allergic to any of the following items?

Y	N	Penicillin	Y	N	Tetracycline	Y	N	Latex
Y	N	Aspirin	Y	N	Dental Anesthetics	Y	N	Any Metal / Plastic
Y	N	Erythromycin	Y	N	Codeine	Y	N	Other

Please list any other drugs that you are allergic to: ________________

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5 DENTAL HISTORY

What are the main concerns that you would like orthodontics to accomplish?

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____

Have you ever been evaluated for orthodontic treatment? ❏ No ❏ Yes

Have you ever had a serious / difficult problem associated with any previous dental work? ❏ No ❏ Yes

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ❏ No ❏ Yes

Do you like your smile? ❏ No ❏ Yes Do your gums bleed? ❏ No ❏ Yes

Have you ever had an injury to your: Mouth Teeth Chin (circle)

Do you have any speech problems? ______________________

____

Do you generally breathe through your mouth? Y N Awake? Y N Asleep?

Do you have any missing or extra permanent teeth? ❏ No ❏ Yes

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 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 with my informed consent that I may need during diagnosis and treatment.

____

Signature of parent or guardian Date

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 this office, use the services of one or more credit reporting services.

____

Signature of parent or guardian Date

The parent or Guardian who accompanies the child is responsible for payment. Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Office Use Only Office Use Only **Office Use Only** Office Use Only **Office Use Only** Office Use Only

I verbally reviewed the medical / dental information above with the patient named herin: Initials _______ Date __________

Doctor's Comments:

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