

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Confidential Responsible Party Information

Name _____ Marital Status _____
Last First Middle

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Confidential Patient Information

Patient's Name _____ Sex: Male Female
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

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

Insurance Information

Policy Holder's Name _____ Soc. Sec. # _____

Insurance Company _____ Group Number _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Do you have dual coverage? Y N If yes:

Policy Holder's Name _____ Soc. Sec. # _____

Insurance Company _____ Group Number _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

Updates (date & initials) _____

(OVER)

Dental History

Why are you interested in orthodontic treatment? _____
 General Dentist _____ Date of last dental care _____
 Have you ever been evaluated for orthodontic treatment? Y N
 Do you now or have you ever experienced pain or discomfort in your jaw joint? Y N
 Have you ever experienced a mouth or chin injury? Y N
 Do you have speech problems? _____
 Do you usually breathe through your mouth while awake? Y N Or asleep? Y N
 Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? Y N
 Current or past habits affecting the mouth or teeth: Thumb sucking Nail biting Other _____
 Other information about your dental health or previous treatment: _____

Medical History

Physician's name _____ Phone _____
 Date of last visit _____ Have you ever had any serious illnesses or operations? Y N
 If yes, describe _____
 Are you currently under a physician's care? Y N If yes, describe _____
 Have you ever had a blood transfusion? Y N If yes, give approximate dates _____
 Women: Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N
 Check (✓) yes or no to the following:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Positive | <input type="checkbox"/> Y <input type="checkbox"/> N Cough up blood | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney disease or malfunction | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anaphylaxis | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Liver disease | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Material allergies (latex, wool, metal, chemicals) | <input type="checkbox"/> Y <input type="checkbox"/> N Sinus problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis, Rheumatism | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral valve prolapse | <input type="checkbox"/> Y <input type="checkbox"/> N Skin rash |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial heart valves | <input type="checkbox"/> Y <input type="checkbox"/> N Food allergies | <input type="checkbox"/> Y <input type="checkbox"/> N Nervous problems | <input type="checkbox"/> Y <input type="checkbox"/> N Spina Bifida |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial joints | <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker/Heart Surgery | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric care | <input type="checkbox"/> Y <input type="checkbox"/> N Surgical implant |
| <input type="checkbox"/> Y <input type="checkbox"/> N Atopic (allergy prone) | <input type="checkbox"/> Y <input type="checkbox"/> N Heart murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Rapid weight gain or loss | <input type="checkbox"/> Y <input type="checkbox"/> N Swelling of feet or ankles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Back problems | <input type="checkbox"/> Y <input type="checkbox"/> N Heart problems, Describe: _____ | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid disease or malfunction |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood disease | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia/Abnormal bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Respiratory treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Tobacco habit |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes | <input type="checkbox"/> Y <input type="checkbox"/> N Respiratory disease | <input type="checkbox"/> Y <input type="checkbox"/> N Tonsillitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemical dependency | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet fever | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure | | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcer/Colitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Circulatory problems | <input type="checkbox"/> Y <input type="checkbox"/> N Jaw pain | | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cortisone treatments | | | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cough, persistent | | | |

List medications you are taking, if any:

List drug allergies, if any:

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the orthodontist to help determine appropriate and healthful orthodontic treatment. If there is any change in my medical status, I will inform the orthodontist.

I authorize the insurance company indicated on this form to pay to the orthodontist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the orthodontist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

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