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 and **bring it to the Exam Visit**. If you have questions we'll be glad to help you. We look forward to working with you.

Adult Information

Name_____ Soc. Sec. #_____
(Last) (First) (Initial)

Address_____

City_____ State_____ Zip_____ Phone_____

Sex: M___ F___ Age_____ Birthdate _____ Single ___ Married ___ Widowed ___ Separated ___ Divorced___

Person responsible for account_____ Patient employed by_____

Cell Phone_____ Email_____ Work Phone_____

Who may we thank for referring you?_____ Dentist:_____

Notify in case of emergency_____ Home Phone_____ Work Phone_____

Primary Orthodontic Insurance

Insured_____
(Last) (First) (Initial)

Relation to Patient_____ Birthdate_____ Soc. Sec. #_____
Address *(if different from patient)*_____ Home Phone_____
City_____ State_____ Zip_____
Person Responsible Employed by_____ Occupation_____
Business Address_____ Business Phone_____
Insurance Company_____ Phone_____ Group #_____

Additional Orthodontic Insurance

Is patient covered by additional orthodontic insurance? Yes___ No___
Subscriber Name_____ Relation to Patient_____ Birthdate_____
Address (*if different from patient*)_____ Soc. Sec. #_____
City_____ State_____ Zip_____ Phone_____
Subscriber Employed by _____ Phone_____
Insurance Company_____ Phone_____ Group #_____

Dental History

Why are you interested in orthodontic treatment?_____
Date of last dental care_____ Have you ever had orthodontic treatment? Yes ___ No ___
Do you now or have you ever experienced pain or discomfort in your jaw joint? Yes ___ No___
Have you ever experienced a mouth or chin injury? Yes ___ No ___
Do you have speech problems?_____
Do you usually breathe through your mouth while awake? Yes ___ No ___ or asleep? Yes ___ No___
Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? Yes___ No___
Current or past habits affecting the mouth or teeth: Thumb sucking ___ Nail biting ___ Other_____
Other information about your dental health or previous treatment_____

Please complete both sides

Medical History

Physician's name_____Phone_____

Date of last visit_____Have you had any serious illnesses or operations? Yes ___ No___

If yes, describe_____

Are you currently under physician care? Yes ___ No___ If yes, describe_____

Have you ever had a blood transfusion? Yes ____ No____ If yes, give approximate dates_____
Women: Are you pregnant? Yes____ No____ Nursing? Yes ____ No____ Taking birth control pills? Yes____ No____
Check (√) if you have had any of the following:

- ❑ AIDS/HIV Positive
- ❑ Anaphylactic Shock
- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ Artificial heart valves
- ❑ Artificial joints
- ❑ Asthma
- ❑ Allergy prone
- ❑ Back problems
- ❑ Blood disease
- ❑ Cancer
- ❑ Chemical dependency
- ❑ Chemotherapy
- ❑ Circulatory problems
- ❑ Cortisone treatments
- ❑ Cough, persistent
- ❑ Cough up blood
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart murmur Need premed before dental work?_____
- ❑ Heart problems Describe_____
- ❑ Hemophilia/ Abnormal bleeding
- ❑ Herpes
- ❑ Hepatitis
- ❑ High blood pressure
- ❑ Kidney disease or malfunction
- ❑ Liver disease
- ❑ Material allergies (**latex**, wool, metal, chemicals)
- ❑ Mitral valve prolapse
- ❑ Nervous problems
- ❑ Pacemaker/Heart surgery
- ❑ Psychiatric care
- ❑ Rapid weight gain or loss
- ❑ Radiation treatment
- ❑ Respiratory disease
- ❑ Rheumatic/Scarlet fever
- ❑ Shingles
- ❑ Shortness of breath
- ❑ Sinus problems
- ❑ Spina Bifida
- ❑ Skin rash
- ❑ Stroke
- ❑ Surgical implant
- ❑ Swelling of feet or ankles
- ❑ Thyroid disease or malfunction
- ❑ Tobacco habit
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer/Colitis
- ❑ Venereal disease

List medications you are taking if any:

_____

_____

List drug allergies, if any:

_____

_____

Authorization

1. The undersigned hereby authorizes the doctor to do an exam and request any necessary x-rays, study models, photographs or diagnostic aids deemed appropriate.
2. I also authorize the doctor to perform all recommended treatment mutually agreed upon by both and consent that the doctor choose and employ such assistance as deemed fit to provide quality care.
3. I consent to allowing my diagnostic records to be used for professional, educational presentations.

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 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 made.