

W elcome!



Please fill out this form completely to the best of your ability. The better we communicate, the better we can care for you. All patient records are kept strictly confidential.

Tell Us About Yourself

Today's Date: _____

Name: _____
LAST FIRST MI

Prefer to be called: _____ ☐ Female ☐ Male

Birthdate: ____/____/____ Age: _____

SS#: ____-____-____

Home Address: _____

____ CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home #: (____) _____

Work #: (____) _____ Ext. _____

Cell phone #: (____) _____

Email address: _____

Employer: _____

Occupation: _____

When and where are the best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

General Dentist: _____

Last Visit Date: _____

Spouse's Name: _____

In the event of an emergency, who should we contact?

Name: _____

Cell #: _____ Home #: _____

Primary Orthodontic Insurance

Insurance Co. Name: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____

SS #: _____

ID #: _____

Medical History

Physician's Name: _____

Phone #: (____) _____ Date of last visit: _____

Please list any prescriptions/over-the-counter drugs that you are currently taking: _____

Please list all drugs/things that you are allergic to: _____

For women, are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Do you smoke? ☐ Never ☐ Seldom ☐ Frequently

Do you need to take antibiotics before getting your teeth cleaned at the dentist? ☐ Yes ☐ No

How often do you take NSAIDS?

(ex. Advil, Motrin, etc.) ☐ Never ☐ Seldom ☐ Frequently

Do you take any steroids? ☐ Yes ☐ No

Do you take a fish oil supplement? ☐ Yes ☐ No

Are you taking any medications for osteoporosis? ☐ Yes ☐ No

Do you take any Bisphosphonate medications (Fosamax, Boniva, Actonel, Didronel, Aredia, Skelid or Zometa)?

☐ Yes ☐ No

CONTINUED ON OTHER SIDE

Person Responsible for Account:

Work #: (____) _____ Ext. _____

Home #: (____) _____

Billing Address: _____

Relationship: _____

SS #: _____

Employer: _____

Medical History continued

Have you ever had any of the following medical problems?

Y N Abnormal Bleeding	Y N Heart Surgery / Pacemaker
Y N Anemia / Radiation Treatment	Y N Hemophilia
Y N Artificial Bones / Joints / Valves	Y N Hepatitis
Y N Asthma / Arthritis	Y N High / Low Blood Pressure
Y N Blood Transfusion	Y N HIV+ / AIDS
Y N Cancer / Chemotherapy	Y N Hospitalized For Any Reason
Y N Congenital Heart Defect	Y N Kidney / Liver Problems
Y N Diabetes	Y N Mitral Valve Prolapse
Y N Difficulty Breathing	Y N Psychiatric Problems
Y N Drug / Alcohol Abuse	Y N Rheumatic / Scarlet Fever
Y N Emphysema / Glaucoma	Y N Severe / Frequent Headaches
Y N Epilepsy / Seizures / Fainting	Y N Tuberculosis
Y N Fever Blisters / Herpes	Y N Sinus Problems
Y N Heart Attack / Stroke	Y N Allergic to Latex
Y N Heart Murmur	Y N Allergic to Metals / Plastics

Please list any serious medical conditions that you have or ever had:

Dental History

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

Have you been evaluated for orthodontic treatment in the past year? ☐ Yes ☐ No

Have you ever had a problem associated with any previous dental work? ☐ Yes ☐ No

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

Explain: _____

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

Do you have any speech problems? ☐ Yes ☐ No

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

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services that I may need during diagnosis and treatment with my informed consent. I understand that I am responsible for full payment of services rendered and also responsible for paying any co-payments and deductibles that my insurance does not cover.

Signature

Date

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

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

Doctors Comments:

Initials: _____ Date: _____
