

# WELCOME

**T**he benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum

oral health. Please fill out this form completely. The better we communicate, the better we can care for you. ☺

## ABOUT YOU

Today's Date: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Name: \_\_\_\_\_  
LAST FIRST MI MR MRS MS DR

I prefer to be called: \_\_\_\_\_  Male  Female

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

Home Address: \_\_\_\_\_  
APT/CONDO #:

CITY STATE ZIP

Single  Married  Divorced  Widowed  Separated

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

Phone Number: \_\_\_\_\_

Last Visit Date: \_\_\_\_\_

## SPOUSE INFORMATION

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

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

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

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

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

Billing Address: \_\_\_\_\_

CITY STATE ZIP

Relation: \_\_\_\_\_ SS #: \_\_\_\_\_

Employer: \_\_\_\_\_ DL #: \_\_\_\_\_

## ORTHODONTIC INSURANCE

### Primary

Orthodontic Coverage:  Yes  No

Dental Coverage:  Yes  No

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

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

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

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

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

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

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

CITY STATE ZIP

### Secondary

Orthodontic Coverage:  Yes  No

Dental Coverage:  Yes  No

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

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

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

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

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

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

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

CITY STATE ZIP

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

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

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

## MEDICAL HISTORY

Do you have a personal physician?  Yes  No

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

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

# MEDICAL HISTORY *continued*

# DENTAL HISTORY

Your current physical health is:  Good  Fair  Poor

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

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

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

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

For Women: Are you taking birth control pills?  Yes  No

Are you pregnant?  Yes  No Week #: \_\_\_\_\_

Are you nursing?  Yes  No

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

- |  |                                  |
|--|----------------------------------|
| Y N Abnormal Bleeding                  | Y N Hemophilia                   |
| Y N Anemia                             | Y N Hepatitis                    |
| Y N Artificial Bones / Joints / Valves | Y N High / Low Blood Pressure    |
| Y N Asthma / Arthritis                 | Y N HIV+ / AIDS                  |
| Y N Blood Transfusion                  | Y N Hospitalized for Any Reason  |
| Y N Cancer / Chemotherapy              | Y N Kidney Problems              |
| Y N Congenital Heart Defect            | Y N Mitral Valve Prolapse        |
| Y N Diabetes                           | Y N Psychiatric Problems         |
| Y N Difficulty Breathing               | Y N Radiation Treatment          |
| Y N Drug / Alcohol Abuse               | Y N Rheumatic / Scarlet Fever    |
| Y N Emphysema                          | Y N Severe / Frequent Headaches  |
| Y N Epilepsy / Seizures / Fainting     | Y N Shingles                     |
| Y N Fever Blisters / Herpes            | Y N Sickle Cell Disease / Traits |
| Y N Glaucoma                           | Y N Sinus Problems               |
| Y N Heart Attack / Stroke              | Y N Tuberculosis (TB)            |
| Y N Heart Murmur                       | Y N Ulcers / Colitis             |
| Y N Heart Surgery / Pacemaker          | 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 Dental Anesthetics | Y N Penicillin   |
| Y N Any Metals/Plastics | Y N Erythromycin       | Y N Tetracycline |
| Y N Codeine             | Y N Latex              | Y N Other        |

Please list any other drugs/materials that you are allergic to: \_\_\_\_\_

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

Have you ever had or been evaluated for orthodontic treatment?  Yes  No

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

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

Your current dental health is:  Good  Fair  Poor

Do you like your smile?  Yes  No Gums ever bleed?  Yes  No

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

Do you have any speech problems?  Yes  No  
 If yes, what? \_\_\_\_\_

Do you generally breathe through your mouth?  Yes  No  
 If yes, please circle: While Awake? While Asleep?

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

Have you ever taken Fosamax or any other bisphosphonate?  Yes  No  
 If yes, when? \_\_\_\_\_

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

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Thank you for filling out this form completely.**

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.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

**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

I verbally reviewed the medical / dental information above with the patient named herein. Initials: \_\_\_\_\_ Date: \_\_\_\_\_

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