WELCOME TO THE ORTHODONTIST

The benefits of a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset.

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ABOUT YOU

Today's Date: _____/_____/_____ ❑Male ❑Female

E-Mail Address: ______________________________

Your Name: ______________________________

I prefer to be called: ______________________________

Birthdate: _____/_____/_____ Age: __________

Your Home Phone #: ( ) ______________________

Your Cell Phone #: ( ) ______________________

Your Home Address: ______________________

City/State/Zip: ______________________

❑Single ❑Married ❑Divorced ❑Widowed ❑Separated

Your Employer: ______________________

Your Work Phone #: ( ) ______________________

May we contact you at work? **❑YES ❑NO**

Whom may we thank for referring you? ______________________

Other family members seen by us: ______________________

General Dentist: ______________________

Last Visit Date: ______________________

SPOUSE INFORMATION

His / Her Name: ______________________

Employer: ______________________

Work phone #: ( ) ______________________ ext.________

Birthdate: ______/______/______

ORTHODONTIC INSURANCE

Orthodontic Coverage: ❑YES ❑NO

Insurance Co. Name: ______________________

Insurance Co. Address: ______________________

Insurance Co. Phone #: ( ) ______________________

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

Policy Holder's Name: ______________________

Policy Holder's Birthdate: _____/_____/_____

ID Number: ______________________

Policy Holder's Employer: ______________________

EMERGENCY CONTACT

Name: ______________________ Relation: ______________

Phone #: ( ) ______________________

Address: ______________________

____

MEDICAL HISTORY

Do you have a personal physician? ❑YES ❑NO

Physician's Name: ______________________

Physician's Phone #: ( ) ______________________

Date of Last Visit: ______________________

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: ______________________

CONTINUED ON BACK ►

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

MEDICAL HISTORY CONTINUED...

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

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 Penicillin	Y N Codeine
Y N Any Metals/Plastics	Y N Erythromycin	Y N Tetracycline
Y N Latex	Y N Dental Anesthetics	
Y N Other		

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

____

____

DENTAL HISTORY

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 your gums ever bleed? ❑ YES ❑NO

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

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

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 THIS OUT 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.

____

Signature Date

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

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