Welcome

1 About You

Today's Date ______________________________

Name ______________________________
Last First MI MR MRS MS DR

I prefer to be called ________________ ☐Male ☐Female

Birthdate ____/____/____ Age:_____

SS# ______________________________

Home Address ______________________________
Apt #

____
City State Zip

☐ Single ☐ Partnered ☐ Divorced ☐ Married ☐ Separated ☐ Widowed

Hm # (____)____________ Cell # ______________

Wk # (____)_________Ext._____ How long at this address_____

Previous Address (if less than 3 years) ______________

Employer ______________________________

Job Title________________ How long ____________

Whom may we thank for referring you? ____________

Other family members seen us ______________

General Dentist ______________________________

2 Spouse Information

His / Her Name ______________________________

SS #______________________________

Employer ______________________________

Job Title_________________ How long ___________

Wk # (____)_________Ext._____ Cell # (____) ________

Birthdate ____/_____/______

3 Account Information

Person Responsible for Account________________

SS # ______________________________

Wk # (____)_________Ext._____ Hm # (____) _________

Cell # (____)_________

Billing address______________________________

Relation ______________________________

Employer ______________________________

4 Personal Email

____

(For e-mailing appointment reminders ONLY)

5 Orthodontic Insurance

Primary

Orthodontic Coverage? ☐ Yes ☐ No

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name ______________________________

Insurance Co. Address ______________________________

Insurance Co. City & State ______________________

Insurance Co. Phone # (_____)____________________

Group # (Plan, Local or Policy #)_________________

Insured's Name ______________________________

SS#/ID# ______________________________

Relationship ______________________________

Insured's Employer ______________________________

Insured's Birthdate ____/____/____

Secondary

Orthodontic Coverage? ☐ Yes ☐ No

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name ______________________________

Insurance Co. Address ______________________________

Insurance Co. City & State ______________________

Insurance Co. Phone # (_____)____________________

Group # (Plan, Local or Policy #)_________________

Insured's Name ______________________________

SS#/ID# ______________________________

Relationship ______________________________

Insured's Employer ______________________________

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

His / Her Name ______________________________

Relation ______________________________

Wk # (____)_________Ext._____ Hm # (____) _________

Cell # (____)_________

6 Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name ______________________________

Phone # (_____) ______________________________

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 your pregnant? ☐ Yes ☐ No

If yes, week #______________________________

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

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

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

____

____

7 Dental History

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

____

Has 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

Have 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

Have you ever had an injury to your: Mouth Teeth Chin

Do you have any speech problems? ______________________________

____

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

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

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

1) 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 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 any necessary dental services that I may need during diagnosis and treatment with my informed consent.

2) We will file your insurance claim for you, 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.

3) Notice of Privacy Practice: You have the right to read the Notice of Privacy Practices which provides a description of office treatment, payment activities and healthcare operations, of the uses and disclosures we may make to your protected health information. We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. We may use your photos for demonstration purposes.

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

Signature for items 1, 2 ,3, & 4

____
Signature Date