



## Thank You For Selecting Our Orthodontic Team!

We will strive to provide you with the best orthodontic care. To help us meet your needs, please fill out this form completely. If you have any questions or need assistance, please ask us—we will be happy to help!

### >>> Patient Information <<<

(confidential) Date: \_\_\_\_\_  
 Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Is the Patient (please check)  Minor  Single  Married  
 Person to Contact in Case of Emergency \_\_\_\_\_ Phone \_\_\_\_\_

If Patient is a Minor -

Father's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Mother's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

If Patient is an Adult -

Your Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Did your General Dentist refer you?  Yes If not, how did you find out about us? \_\_\_\_\_

### >>> Responsible Party Information <<<

Name of Person Responsible for this Account \_\_\_\_\_ Relationship \_\_\_\_\_  
 Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
 How long at this address? \_\_\_\_\_ Previous Address (if less than 3 years) \_\_\_\_\_  
 Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
 E-Mail Address \_\_\_\_\_ Cell Phone \_\_\_\_\_

### >>> Dental Insurance Information <<<

Name of Insured \_\_\_\_\_ Relationship \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_  
 Employer's Name \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy ID # \_\_\_\_\_  
 Insurance Company Address \_\_\_\_\_ City \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_ Phone Number \_\_\_\_\_ \*

DO YOU HAVE ADDITIONAL INSURANCE? If yes, please complete the following:

Name of Insured \_\_\_\_\_ Relationship \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_  
 Employer's Name \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy ID # \_\_\_\_\_  
 Insurance Company Address \_\_\_\_\_ City \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_ Phone Number \_\_\_\_\_

Thank You! Please complete the back side of this form →

# Patient Dental History

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

\_\_\_\_\_

\_\_\_\_\_

Has the patient ever been evaluated or had orthodontic treatment before?

Yes  No

Have there ever been any injuries to the face, mouth, teeth or chin?

Yes  No

Has the patient been informed of any missing or extra permanent teeth?

Yes  No

Has the patient ever had any pain/tenderness in the jaw joint?

Yes  No

Name of Dentist \_\_\_\_\_ Phone # \_\_\_\_\_

Does the patient have any speech problems? \_\_\_\_\_

Has the patient ever had a serious/difficult problem associated with any previous dental work?  Yes  No

The patient's current dental health is:  Good  Fair  Poor

Has the patient ever had any of the following diseases or medical problems? Please discuss any of the marked items or any other medical problems that the patient has had in the space below.

- |                                |   |
|--------------------------------|---|
| Y N Anemia/Radiation Treatment | Y N Heart Surgery/Pacemaker               |
| Y N Any Hospital Stays         | Y N Hemophilia/Abnormal Bleeding          |
| Y N Any Operations             | Y N Hepatitis                             |
| Y N Artificial Valves          | Y N High/Low Blood Pressure               |
| Y N Arthritis                  | Y N HIV+/AIDS                             |
| Y N Asthma                     | Y N Kidney/Liver Problems                 |
| Y N Blood Transfusion          | Y N Mitral Valve Prolapse                 |
| Y N Cancer/Chemotherapy        | Y N Psychiatric Problems                  |
| Y N Congenital Heart Defect    | Y N Respiratory Problems                  |
| Y N Convulsions/Epilepsy       | Y N Rheumatic/Scarlet Fever               |
| Y N Diabetes                   | Y N Severe/Frequent Headaches             |
| Y N Drug/Alcohol Abuse         | Y N Shingles                              |
| Y N Emphysema/Glaucoma         | Y N Sinus Problems                        |
| Y N Fever Blisters/Herpes      | Y N Tuberculosis                          |
| Y N Handicaps/Disabilities     | Y N Ulcer/Colitis                         |
| Y N Heart Attack/Stroke        | Y N Venereal Disease                      |
| Y N Hearing Impairment         | Y N Orthopedic Total Joint                |
| Y N Heart Murmur               | Y N Any Complications w/ Orthopedic Joint |

\_\_\_\_\_

\_\_\_\_\_

# Patient Habits

Does/did the patient have any of the following habits?

- Y N Clenching Teeth
- Y N Grinding Teeth
- Y N Lip Sucking/Biting
- Y N Mouth Breather
- Y N Thumb/Finger Sucking (circle one)  
Past habit or current habit (circle one)
- Y N Tongue Thrust

Is the patient allergic to any of the following?

- |                        |   |
|------------------------|---|
| Y N Aspirin            | Y N Latex                                 |
| Y N Any Metal/Plastic  | Y N Penicillin or any related cillin drug |
| Y N Codeine            | Y N Tetracycline                          |
| Y N Dental Anesthetics | Y N Iodine                                |
| Y N Erythromycin       | Y N Other                                 |
| Y N Any Sulfá Drug     |   |

# Patient Medical History

Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Date of last visit \_\_\_\_\_

Patient's physical health is:  Good  Fair  Poor

Is the patient under the care of a physician?  Yes  No

Please list all drugs that the patient is taking: \_\_\_\_\_

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

Are you nursing?  Yes  No

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list any other drugs that the patient is allergic to:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does the patient have any condition(s) requiring pre-medication?

\_\_\_\_\_

# Authorization and Release

I certify that I have answered the above questionnaire accurately and to the best of my knowledge. I understand that providing incorrect information can be dangerous to my medical and dental health. I authorize the office to release any information including the diagnosis and records of any treatment or examination rendered to the patient during the period of such orthodontic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the orthodontist insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on the patient's behalf. I understand that where appropriate, credit bureau reports may be obtained.

X \_\_\_\_\_  
Signature of patient (or parent if minor)

\_\_\_\_\_  
Date