WELCOME

Tell Us About Yourself

Today's Date:

Name:
Last First M.I.

Birthdate: ___**Male** ___**Female**

I prefer to be called:

Home #: **Cell #:**

Work #: **Ext:**

Address:

City State Zip

Email Address:

Preferred mail method: *Circle* Standard Mail Email

General Information

Whom do we thank for referring you?

Dentist: **Date of Last Visit:**

Dentist Phone #:

Physician: **Date of Last Visit:**

Physician Phone #:

Are you currently under the care of a doctor? **Y** **N**

___Single ___Married ___Partnered
___Divorced/Separated ___Widowed

Insurance Information

Primary Dental Insurance Company Name

Subscriber's Name:

Subscriber Birthdate:

Relationship to Subscriber: ___Self ___Spouse ___Parent/Guardian ___Other:

Subscriber's Address:

City State Zip

Insurance Phone #:

Group #:

Member ID # (or SSN if not applicable)**:**

Subscriber's Employer:

Employer Address:

City State Zip

Secondary Dental Insurance Company Name

Subscriber's Name:

Subscriber Birthdate:

Relationship to Subscriber: ___Self ___Spouse ___Parent/Guardian ___Other:

Subscriber's Address:

City State Zip

Insurance Phone #:

Group #:

Member ID # (or SSN if not applicable)**:**

Subscriber's Employer:

Employer Address:

City State Zip

Authorization

I understand that I am responsible for payment of services at the time they are rendered. Insurance claims will be submitted and payment from the insurance company will be sent to the insured. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I further authorize the use of this signature on all my insurance submissions and credit card payments, whether manual or electronic.

Signature Date

Dental & Medical History

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

Have you ever been evaluated or had orthodontic treatment before? Y N

Have you had any metal rods, pins? Y N

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

Do you have any missing or extra permanent teeth? Y N

Have you ever had any pain/tenderness in your jaw joint (TMJ/TMD) Y N

Do you clench or grind your teeth? Y N

Do you smoke or use tobacco in any other form? Y N

Are you taking any prescription/over the counter drugs? Y N

Please list each one:

Do you still have wisdom teeth? Y N

Do you breathe through your mouth? Y N

For Women: are you using a method of birth control? Y N

Are you pregnant? Y N Week #

Are you nursing? Y N

Have you experienced the following medical problems?

Abnormal Bleeding	Y N	Heart Murmur	Y N
AIDS/HIV+	Y N	Hepatitis	Y N
Alcohol/Drug Abuse	Y N	Herpes/Fever Blisters	Y N
Anemia	Y N	High Blood Pressure	Y N
Any Hospitalizations	Y N	Kidney Problems	Y N
Arthritis	Y N	Liver Disease	Y N
Artificial bones/joints	Y N	Low Blood Pressure	Y N
Asthma	Y N	Lupus	Y N
Blood Transfusing	Y N	Mitral Valve Prolapse	Y N
Cancer/Chemotherapy	Y N	Pacemaker	Y N
Colitis	Y N	Prosthetics	Y N
Congenital Heart Defect	Y N	Psychiatric Problems	Y N
Convulsions	Y N	Radiation Treatment	Y N
Diabetes	Y N	Rheumatic Fever	Y N
Difficulty Breathing	Y N	Scarlet Fever	Y N
Emphysema	Y N	Seizures	Y N
Epilepsy	Y N	Shingles	Y N
Fainting	Y N	Sickle Cell	Y N
Frequent Headaches	Y N	Sinus Problems	Y N
Glaucoma	Y N	STD's	Y N
Hay fever	Y N	Stroke	Y N
Hearing Impairment	Y N	Thyroid Problems	Y N
Heart Attack/Surgery	Y N	Tuberculosis (TB)	Y N
		Ulcers	Y N

Please discuss any serious medical problems you have had:

Are you allergic to any of the following?

Aspirin	Y N	Erythromycin	Y N	Penicillin	Y N
Codeine	Y N	Anesthetics	Y N	Latex	Y N
Metals	Y N	Tetracycline	Y N	Other	Y N

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

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

I understand that the information I have given is correct to the best of my knowledge, that it will be help in the strictest confidence and that 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/orthodontic services I may need.

Signature Date

OFFICE USE ONLY

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

Signature of Orthodontist Date

Doctor's Comments: