

Orthodontics for Children and Adults

# Welcome

We would like to welcome you to our office. Our goal is to make every visit pleasant and educational. We strive to teach good oral care that will enable you to have a beautiful smile that can last a life time.

Who may we thank for referring you? \_\_\_\_\_ Today's Date \_\_\_\_\_

### Patient Information

Patient's Name \_\_\_\_\_ Male  Female  D.O.B \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City, State \_\_\_\_\_ Zip code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ E-mail \_\_\_\_\_ S. S. # \_\_\_\_\_

School/Employer \_\_\_\_\_ Address or City \_\_\_\_\_

Do you have any family members in our office that has had or is currently in orthodontic treatment? Yes No

Name \_\_\_\_\_

### Responsible Party Information (for patients under the age of 18)

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

### Insurance Information

Insured's Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

Employer \_\_\_\_\_ Birth Date \_\_\_\_\_

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

Do you have dual coverage? Yes  No  If yes, complete the following:

Insured's Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

Employer \_\_\_\_\_ Birth Date \_\_\_\_\_

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

Personal references (please list three people who do not live with you, we can contact in case of an emergency)

Name \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_




Name \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

Name of your dentist \_\_\_\_\_ Phone Number \_\_\_\_\_


Date of the most recent dental exam/cleaning \_\_\_\_\_

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

Are you happy with the way your Smile looks? \_\_\_\_\_

On a scale of 1-10, how motivated are you to start orthodontic treatment? 1- 3  4-7  8-10 

## Health History

Please circle your answer 

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

Do have a personal Physician? Yes No

Physician's name: \_\_\_\_\_

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

Your current Physical Health is: Good Fair Poor

Do you smoke tobacco or use it in any form? Yes No

Have you had any metal rods, pins or implants? Yes No

Taking any prescription/over the counter drugs? Yes No

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

Have you ever taken Phen-fen? Yes No

Also known as Redux or Pondimin.

If so when? \_\_\_\_\_

Are you allergic to any of the following? (Circle)

Aspirin Erythromycin Penicillin

Codeine Jewelry/Metals Tetracycline

Dental Anesthetics Latex Other:

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

Women: Are you taking birth control pills? Yes No

Are you pregnant? Yes NO Week# \_\_\_\_\_

Are you nursing? Yes NO

Y N Abnormal Bleeding/Hemophilia

Y N AIDS

Y N Alcohol/Drug abuse

Y N Anemia

Y N Arthritis

Y N Artificial Bones / joints/ valves

Y N Asthma

Y N Blood transfusion

Y N Cancer/ Chemotherapy

Y N Colitis

Y N Congenital Heart Defect

Y N Diabetes

Y N Difficulty Breathing

Y N Emphysema

Y N Epilepsy

Y N Frequent Headaches

Y N Glaucoma

Y N Hay Fever

Y N Heart Attack/ Surgery

Y N Heart Murmur

Y N Herpes / Fever blisters

Y N High Blood Pressure

Y N HIV

Y N Hospitalized for any reason

Y N Kidney Problems

Y N Liver Disease

Y N Low Blood Pressure

Y N Lupus

Y N Mitral Valve Prolapse

Y N Pacemaker

Y N Psychiatrist Problems

Y N Radiation Treatment

Y N Rheumatic/ Scarlet Fever

Y N Seizures

Y N Shingles

Y N Sickle Disease / Traits

Y N Stroke

Y N Thyroid Problems

Y N Tuberculosis (TB)

Y N Ulcers

Other \_\_\_\_\_

*Our office reserves the right to verify the credit of potential patients and /or parents prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting service. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payments and deductibles that my insurance does not cover. In the event of a default on agreed to payment arrangements, I am responsible for reasonable collection costs.*

Signature (Parents/Responsible Party signature if minor) \_\_\_\_\_ Date \_\_\_\_\_

\*\*\*\*\*Office Use Only\*\*\*\*\*

I verbally reviewed the Medical information with patient named Herein. Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Chief complaint: \_\_\_\_\_

Doctor's comments: \_\_\_\_\_