

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 _____ SS# _____

E-mail _____ School/Employer _____

Do you have any family members in our office that has had or is currently in orthodontic treatment?

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

Name _____ D.O.B _____

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/x-rays _____

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? (please circle individually)

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: _____

Do you have any jaw joint pain? Yes No

Do you have any jaw joint clicking/popping? Yes No

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 Psychiatric Treatment

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: _____

Doctor's comments:
