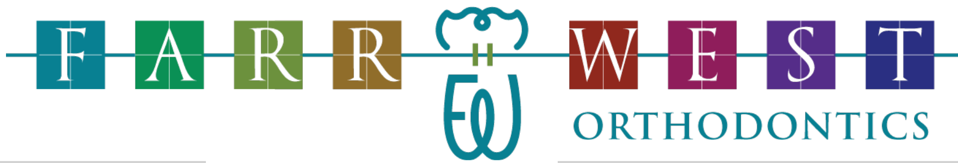

About You

Today's Date: ______________________________
Name: __________________________________
Preferred Name: ___________________________
Social Security #: _________________________
Home Address: ____________________________
____
Birthdate (mm/dd/yyyy): __________________
Gender: ___________________________________
Special interests, hobbies, or sports: ______
____
Whom may we thank for sending you to see us? ______________________________
Occupation: _______________________________
Your Employer: ____________________________
Address: __________________________________
____
Employer Phone #: _________________________
General Dentist: ___________________________
Date of last visit: _________________________

Contact Information

Home Phone #: ____________________________
Work Phone #: _____________________________
Extension #: ________________________
Cell #: _____________________________________
Email: _____________________________________
How would you prefer to receive appointment reminders?

Phone **Text** **Email**

In the event of an emergency, contact:
Name: ______________________________________
Relationship: _______________________________
Work Phone: ________________________________
Home Phone: ________________________________

Primary Orthodontic Insurance

Orthodontic Coverage (yes/no): __________
Insurance Company Name: _______________
Address: ___________________________________
____
Phone #: ___________________________________
Policy or ID#: ______________________________
Policy Owner's Name: ____________________
Relationship to patient: __________________
Policy Owner Birthdate: __________________
Policy Owner's Employer: ________________
____

Secondary Orthodontic Insurance

Orthodontic Coverage (yes/no): __________
Insurance Company Name: _______________
Address: ___________________________________
____
Phone #: ___________________________________
Policy or ID#: ______________________________
Policy Owner's Name: ____________________
Relationship to patient: __________________
Policy Owner Birthdate: __________________
Policy Owner's Employer: ________________
____

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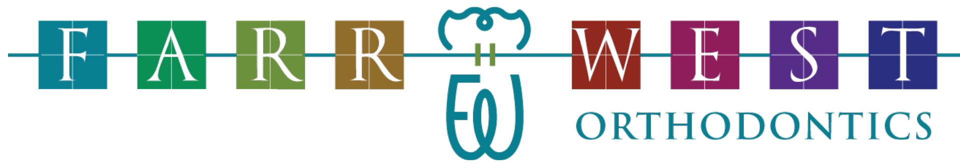

Medical History

Do you have a personal physician? **Yes** **No**
His/Her Name: ______________________________
His/Her Phone: ______________________________
Date of your last doctor visit: ___________
Your current health is (please circle one):
Good **Fair** **Poor**
Are you currently under the care of any physician?
Yes **No**
If yes, please explain: ______________________________
____

Do you smoke or use tobacco in any form?
Yes **No**
Are you presently taking any drugs prescribed by a physician or dentist? **Yes** **No**
If yes please list: ______________________________
____

For women: Are you pregnant? **Yes** **No**
Week # _________

DO YOU NEED TO BE PRE-MEDICATED BEFORE DENTAL TREATMENT? **Yes** **No**
Have you had any serious medical problems in the last 5 years? **Yes** **No**
If yes, please explain: ______________________________
____

Are you allergic to any medication? **Yes** **No**
If yes, please list: ______________________________
____

Do you have any other allergies? **Yes** **No**
If yes, please list: ______________________________
____

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS? PLEASE CIRCLE Y OR N

Y	**N**	Anemia	**Y**	**N**	High/Low Blood Pressure
Y	**N**	Cancer/Chemotherapy	**Y**	**N**	HIV+/AIDS
Y	**N**	Chronic Hepatitis	**Y**	**N**	Kidney Problems
Y	**N**	Diabetes	**Y**	**N**	Psychiatric Problems
Y	**N**	Drug Alcohol Abuse	**Y**	**N**	Severe Headaches
Y	**N**	Epilepsy/Seisures	**Y**	**N**	Shingles
Y	**N**	Cold Sores/Herpes	**Y**	**N**	Sickle Cell Disease
Y	**N**	Heart Attack/Stroke	**Y**	**N**	Sinus Problems
Y	**N**	Heart Murmur/Rheumatic Fever	**Y**	**N**	Tuberculosis (TB)
Y	**N**	Heart Surgery/Pacemaker	**Y**	**N**	Asthma
Y	**N**	Hemophilia/Abnormal bleeding	**Y**	**N**	Osteoporosis/Bone disease
Y	**N**	Autoimmune disease			

OFFICE USE ONLY:
Doctor's Comments ______________________________
____
____

ANY OTHER MEDICAL CONDITIONS
Have you experienced any that are not listed above?
Yes **No**
If yes, please list: ______________________________
____

Dental History

Why have you come to the orthodontist today? ___________
____
____

Do you experience stress or anxiety when you visit a dental office? **Yes** **No**
The approximate date of your last dentist visit: ___________
Your current dental health is:
Good **Fair** **Poor**

Do you like your smile?	**Yes**	**No**
Do your gums ever bleed?	**Yes**	**No**
Have you ever-experienced TMD? (TMJ is discomfort , pain, or clicking of the jaw joint)	**Yes**	**No**
Do you grind your teeth?	**Yes**	**No**
Are you currently in pain?	**Yes**	**No**
Are you under any unusual stress?	**Yes**	**No**

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 the strictest confidence and it is my responsibility to inform this office of any changes in my medical or insurance status. I authorize the dental staff to perform any necessary dental service with my informed consent that I may need during diagnosis and treatment. Also, I guarantee payment of all fees for treatment.*

Assignment of Benefits: I hereby authorized payment to my attending Orthodontist. I understand that I am financially responsible for any charges not covered by this authorization. I also authorize release of any information relating to claims. I understand that where appropriate credit bureau reports may be obtained.

____
Signature Date

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