Welcome

Confidential Patient Information

Date: _____

Name: _____ Marital Status: _____
Last First Middle

Birthdate: ___/___/___ Social Security # _____ DL #: _____

Address: _____
Street City State Zip

How long at this address: _____ ☐Own ☐Rent Previous address: (if less than 3 yrs) _____

Email address: _____

Home phone: (___)_____ Work Phone: (___)_____ Cell Phone: (___) _____

What is the best number / time to reach you? _____

Employer: _____ No. years employed: _____ Occupation: _____

Employer Address: _____
Street City State Zip

Whom may we thank for referring you? _____Other family members seen by us: _____

Dentist Name: _____ Date of last visit? _____

Person Responsible for Account: _____

Spouse Information

His / Her Name: _____ ☐M ☐F

Employer: _____ Occupation: _____ No. years employed: _____

Wk #: (___)_____ Soc. Security #: _____

Birthdate: ____/____/____ DL #: _____

Insurance Information

Policy Holder's Name:_____ Soc. Security #: _____

Insurance Company: _____Group No: _____ Union Local No: _____

Insurance Co. Address: _____ Insurance Co. Phone: (___)_____

Policy Holder's Employer: _____

Do you have dual coverage? No ☐ Yes ☐ If yes: _____

Policy Holder's Name: _____ Soc. Security #: _____

Insurance Company: _____Group No: _____Union Local No: _____

Insurance Co. Address: _____ Insurance Co. Phone: (___)_____

Policy Holder's Employer: _____

Payment is due in full at the time of treatment unless prior arrangements have been approved.

I understand that I am responsible for payment of services rendered and for paying any co-payment that my insurance does not cover, including the deductible. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to the office. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____
SIGNATURE DATE

Emergency Contact:
Relative or friend not living with you.

Name: _____
Relation: _____
Wk #: (___)_____ Hm #: (____)_____

Continued on Back

Medical History

Do you have a personal physician ? ☐Y ☐N

Physician's Name: _____

Ph #: (____)_____ Date of last visit: _____

Your current physical health is: ☐Good ☐Fair ☐Poor

Are you currently under the care of a physician?

Please explain: _____

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

Have you had any metal rods, pins or implants? ☐Y ☐N

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

Please list: _____

Have you ever taken Phen-Fen (Redux or Pondimin) ☐Y ☐N

Have you ever taken bisphosphonates? (ex: Fosamax ☐Y ☐N

WOMEN: Are you taking birth control pills? ☐Y ☐N

Are you pregnant? ☐Y ☐N Week #: _____

Are you nursing? ☐Y ☐N

Have you ever had any of the following diseases or medical problems:

- ☐ Abnormal Bleeding/Hemophilia
- ☐ AIDS/HIV+
- ☐ Alcohol/Drug Abuse
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Bones/Joints/Valves
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer/Chemotherapy
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Surgery
- ☐ Heart murmur
- ☐ Hepatitis
- ☐ Herpes/Fever Blisters
- ☐ High Blood Pressure
- ☐ Hospitalized for Any Reason
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Osteoarthritis
- ☐ Pacemaker
- ☐ Psychiatric Problems
- ☐ Radiation Treatment
- ☐ Rheumatic/Scarlet Fever
- ☐ Seizures
- ☐ Shingles
- ☐ Sickle Cell Disease/Traits Sinus
- ☐ Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis (TB)
- ☐ Ulcers
- ☐ Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Jewelry/Metals
- ☐ Latex
- ☐ Penicillin
- ☐ Tetracycline
- ☐ Other

List any other allergies: _____

Dental History

What would you like orthodontics to accomplish? _____

_____

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

Have you ever had a serious / difficult problem associated with any previous dental work? ☐Y ☐N

Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)? ☐Y ☐N

Your current dental health is: ☐Good ☐Fair ☐Poor

Do you still have wisdom teeth? ☐Y ☐N

Have you ever had an injury to your: ☐Mouth ☐Teeth ☐Chin

Do you have any speech problems? ☐Y ☐N

Do you breathe through your mouth? ☐While Awake ☐While Asleep

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

Do you like your smile? ☐Y ☐N

If not, what would you change? _____

_____

_____

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 that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent. This office reserves the right to verify credit status of potential patients and/or patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

_____

SIGNATURE DATE

Office Use Only

I verbally reviewed the medical / dental information with the patient named herein.

Initials: _____ Date: _____

Doctor's Comments: _____

_____

_____

_____

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.

Medical History Update

Has there been any change in your health status since your last visit? ☐Y ☐N

If yes, please explain: _____

_____

_____

Patient Signature Date

_____

Doctor Signature Date