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The benefits of a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset. Please fill out these forms completely. The better we communicate, the better we can care for you.

ABOUT YOU

Today's date:
Name: Last First MI Mr. Mrs. Ms. Dr.
I prefer to be called: Male Female
Birthdate: / / Age: SS#:
Home address: Apt./Condo #
City State Zip
Single Married Divorced Widowed Separated
Home #: Pager/Other #:
Work #: Ext.: DL#:
Employer:
Employer's address:
How long there: Occupation:
Where & when are best times to reach you?
Whom may we thank for referring you?
Other family members seen by us:
General dentist:
Last visit date:

ORTHODONTIC INSURANCE

PRIMARY
Orthodontic coverage? Yes No
Insurance Co. name:
Insurance Co. address:
Insurance Co. phone #:
Group # (plan, local or policy #):
Insured's name: Relation:
Insured's birthday: / / SS#:
Insured's employer:
SECONDARY
Orthodontic coverage? Yes No
Insurance Co. name:
Insurance Co. address:
Insurance Co. phone #:
Group # (plan, local or policy #):
Insured's name: Relation:
Insured's birthday: / / SS#:
Insured's employer:

SPOUSE INFORMATION

His/her name:
Employer:
Work #: Ext.: SS#:
Birthdate:

E-MAIL ADDRESS

Name:
E-Mail Address:

In the event of an emergency, is there someone who lives near you that we should contact?

Their name:
Work #: Home #:

PERSON RESPONSIBLE FOR ACCOUNT

Name:
Work #: Ext.: Home #:
Billing address: Zip
Relationship: SS #:
Employer: DL #:
of years employed:

MEDICAL HISTORY

Do you have a personal physician? Yes No
Physician's name:
Phone #: Date of last visit:

Form Continued On Back

MEDICAL HISTORY CONT'D.

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain: _____

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

Yes No

Please list each one: _____

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

Y N Heart attack/stroke	Y N Psychiatric problems
Y N Cancer/chemotherapy	Y N Epilepsy/seizures/fainting
Y N Heart murmur	Y N Diabetes
Y N Rheumatic fever	Y N Drug/alcohol abuse
Y N HIV+/AIDS	Y N Tuberculosis (TB)
Y N Heart surgery/pacemaker	Y N Hemophilia/abnormal bleeding
Y N Shingles	Y N Ulcers/colitis
Y N Mitral valve prolapse	Y N Congenital heart defect
Y N Kidney problems	Y N Anemia/radiation treatment
Y N Artificial bones/joints	Y N Asthma/arthritis
Y N Artificial valves	Y N Difficulty breathing
Y N Sinus problems	Y N Hospitalized for any reason
Y N High/low blood pressure	Y N Hepatitis
Y N Fever blisters	Y N Blood transfusion
Y N Severe/frequent headaches	Y N Emphysema/glaucoma
Y N Wears contact lenses	Y N Glaucoma, eye problems
Y N Thyroid disease	Y N Chronic cough

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

Are you allergic to any of the following items?

Y N Penicillin	Y N Tetracycline	Y N Latex
Y N Aspirin	Y N Dental anesthetics	Y N Codeine
Y N Erythromycin	Y N Any metal/plastic	Y N Other

Please list any other drugs that you are allergic to: _____

DENTAL HISTORY

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

Have you ever had or been evaluated for orthodontic treatment?

Yes No

Have you ever had a serious/difficult problem associated with any previous dental work? Yes No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Yes No

Your current dental health is: Good Fair Poor

Do you like your smile? Yes No

Do your gums ever bleed? Good Fair Poor

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

Please Circle

Do you have any speech problems? _____

Do you generally breath through your mouth?

Yes No Awake? Yes No Asleep?

Do you have any missing or extra permanent teeth?

Yes No

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and 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 with my informed consent that I may need during diagnosis and treatment.

Signature _____

Date _____

THANK YOU FOR FILLING OUT THIS FORM COMPLETELY.

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

Signature _____

Date _____

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein, Initials _____ Date _____

Doctor's Comments: _____
