W E L C O M E

Designer SMILES by
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Orthodontics designed to last a lifetime

The benefits of a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset.

Please fill out this form completely. The better we communicate, the better we can care for you.

1 ABOUT YOU

Today's Date:_____

Name: _____ LAST _____ FIRST

MR MRS MS DR ☐ Male ☐ Female

Birth date:__/__/__ SS #:_____

Home Address: _____ APT/CONDO #

_____ CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm#:_____ Mobile #: _____

Wk#:_____ Ext: _____

E-mail: _____

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: _____

Date of Last Visit: _____

2 SPOUSE INFORMATION

His/ Her Name: _____

Employer: _____

Wk#:_____ Ext:_____ SS#: _____

Birth date:__/__/__

Person Responsible for Account: _____

Wk#:_____ Ext:_____ Hm#: _____

Billing Address:_____

Relation:_____ SS#: _____

Employer:_____ DL#:_____

3 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 Birth date:__/__/__ Insured's 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 Birth date: __/__/__ Insured's SS #:_____

Insured's Employer: _____

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

His/ Her Name:_____ Relation: _____

Wk #:_____ Hm #:_____

4 MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name:_____

Phone #:_____ Date of last visit:_____

CONTINUED ON BACK

4 MEDICAL HISTORY

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: _____

For Women: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

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

Y N	Anemia / Radiation Treatment	Y N	Heart Surgery / Pacemaker
Y N	Artificial Bones / Joints	Y N	Hemophilia / Abnormal Bleeding
Y N	Artificial Valves	Y N	Hepatitis
Y N	Asthma / Arthritis	Y N	High / Low Blood Pressure
Y N	Blood Transfusion	Y N	HIV+ / AIDS
Y N	Cancer / Chemotherapy	Y N	Hospitalized for any reason
Y N	Congenital Heart Defect	Y N	Kidney Problems
Y N	Diabetes / Tuberculosis (TB)	Y N	Mitral Valve Prolapse
Y N	Difficulty Breathing	Y N	Psychiatric Problems
Y N	Drug / Alcohol Abuse	Y N	Rheumatic / Scarlet Fever
Y N	Emphysema / Glaucoma	Y N	Severe / Frequent Headaches
Y N	Epilepsy / Seizures	Y N	Shingles
Y N	Fever Blisters / Herpes	Y N	Sinus Problems
Y N	Heart Attack / Stroke	Y N	Ulcers / Colitis
Y N	Heart Murmur	Y N	Venereal Disease

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

_____

_____

_____

_____

_____

5 Are you allergic to any of the following?

Y N Aspirin	Y N Dental Anesthetics	Y N Penicillin
Y N Any Metal / Plastic	Y N Erythromycin	Y N Tetracycline
Y N Codeine	Y N Latex	Y N Other

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

_____

_____

6 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 work? ☐ Yes ☐ No

Do you now or have you 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?** ☐ Yes ☐ No

Have you ever had an injury to you: **Mouth** **Teeth** **Chin** (Please Circle One)

Do you have any speech problem? _____

_____

Do you generally breathe through your mouth? Y N **Awake?** (Please Circle One) Y N **Asleep?** (Please Circle One)

Do you have any missing or extra permanent teeth? ☐ 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 status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature Date

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

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials: Date:

Doctor's Comments: _____

_____

_____