SPECIALISTS in
ORTHODONTICS

ABOUT YOU

Today's Date: ______________________
Month Day Year

Name: ______________________
Last First Middle

Social Security #: ______________________

Nickname: ______________________

Home Address: ______________________

____
Apt# City State Zip

Birthdate: ______________________ ☐ M ☐ F
Month Day Year

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Special Interests, Sports or Hobbies: ______________________

Referred by: ______________________

Occupation: ______________________

Employer: ______________________

Address: ______________________

____
City State Zip

Employer Phone #: ______________________

General Dentist: ______________________

Last Visit Date: ______________________

CONTACT INFORMATION

Home Phone #: ______________________

Work Phone #: ______________________

Extension #: ______________________

Mobile #: ______________________

Email: ______________________

APPOINTMENT REMINDER PREFERENCE

☐ Phone Calls ☐ Text Messages ☐ Emails

IN THE EVENT OF AN EMERGENCY, PLEASE CONTACT:

Name: ______________________

Relationship: ______________________

Work Phone #: ______________________

Home Phone #: ______________________

PRIMARY ORTHODONTIC INSURANCE

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Company Name: ______________________

Insurance Company Address: ______________________

Insurance Company Phone #: ______________________

Policy or ID #: ______________________

Policy Owner's Name: ______________________

Policy Owner's Address: ______________________

Relationship to Patient: ______________________

Policy Owner's Birthdate: ______________________

Policy Owner's Employer: ______________________

SECONDARY ORTHODONTIC INSURANCE

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Company Name: ______________________

Insurance Company Address: ______________________

Insurance Company Phone #: ______________________

Policy or ID #: ______________________

Policy Owner's Name: ______________________

Policy Owner's Address: ______________________

Relationship to Patient: ______________________

Policy Owner's Birthdate: ______________________

Policy Owner's Employer: ______________________

MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

His/Her Name: ______________________

His/Her Phone #: ______________________

Approximate date of last doctor visit: ______________________

Your current physical health is:

☐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: ______________________

____

Are you pregnant? ☐ Yes ☐ No

If yes, what week #: ______________________

DO YOU NEED TO BE ON AN ANTIBIOTIC 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? CIRCLE Y OR N

Y N Anemia
Y N Cancer/Chemotherapy
Y N Chronic Hepatitis
Y N Diabetes
Y N Drug/Alcohol Abuse
Y N Epilepsy/Seizures/Fainting
Y N Fever Blisters/Herpes
Y N Heart Attack/Stroke
Y N Heart Murmur/Rheumatic Fever
Y N Heart Surgery/Pacemaker
Y N Hemophilia/Abnormal Bleeding
Y N High/Low Blood Pressure
Y N HIV+ /AIDS
Y N Kidney Problems
Y N Psychiatric Problems
Y N Severe Headaches
Y N Shingles
Y N Sickle Cell Disease
Y N Sinus Problems
Y N Tuberculosis (TB)
Y N Asthma

OFFICE USE ONLY:

Doctor's Comments: ______________________

____

OTHER MEDICAL CONDITIONS

Any experienced medical conditions 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 dentist office? ☐ 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 experienced TMJ symptoms? ☐ Yes ☐ No
(TMJ is discomfort, pain, or clicking in the jaw joint)

Do you grind your teeth? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Are you under any unusual stress at home or at work?

☐ 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.

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Signature Date

MEDICAL HISTORY UPDATES

FOR OFFICE USE ONLY

Changes: ______________________ Date: ________

Patient Signature: ______________________

Dental Staff Signature: ______________________

Changes: ______________________ Date: ________

Patient Signature: ______________________

Dental Staff Signature: ______________________