WELCOME TO OUR OFFICE

We would like to welcome you to our office. In an effort to provide the best service possible, we ask you to fill out both pages of this form as completely as possible. Thank you for your cooperation.
All information will be kept in strict confidence.

PATIENT INFORMATION:

Last Name: ______

First Name: ______

I prefer to be called: ______

Birthdate: ____/____ / ____ ❑ Male ❑ Female
M D Y

Address: ______

______

Home Phone: ______

Work Phone: ______

Cell Phone: ______

Email: ______

Other Family members seen at this office:

______

Name of Siblings: ______

______

INSURANCE INFORMATION:

Our office bills the Patient or Responsible Party directly for all services rendered. We will complete the necessary forms for your submission to receive the amount of orthodontic coverage to which you are entitled.

Do you have orthodontic coverage?

❑ Yes ❑ No ❑ Dual ❑ Unsure

1. Subscribers Name: ______
   Insurance Company: ______
   Employer: ______
   Policy/Contract #: ______
   I.D./Certificate #: ______

2. Subscribers Name: ______
   Insurance Company: ______
   Employer: ______
   Policy/Contract #: ______
   I.D./Certificate #: ______

RESPONSIBLE PARTY INFORMATION (if under 18)

Parents Marital Status (Please circle):

Married Divorced Separated Partnered Single Widowed

MOTHER (❑ **Guardian**):

Name: ______
First Last

Address (if not same as patient):

______

Home Phone: ______

Work Phone: ______

Cell Phone: ______

Email: ______

How do you prefer to be contacted? (please circle all that apply)

Home Work Cell Email

FATHER (❑ **Guardian**):

Name: ______
First Last

Address (if not same as patient):

______

Home Phone: ______

Work Phone: ______

Cell Phone: ______

Email: ______

How do you prefer to be contacted? (please circle all that apply)

Home Work Cell Email

Person(s) responsible for payments on account:

❑ Mother ❑ Father ❑ Other

Name of Other Party: ______

Person responsible for making appointments:

Name: ______ Relation: ______

PATIENT'S MEDICAL INFORMATION:

Physician's Name: ____________________

Date of last medical exam: ____________________

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

____

Has there been any change in your general health in the past year? ❑ Yes ❑ No

If yes, please explain: ____________________

____

Are you taking any prescription/over-the-counter medications of any kind? ❑ Yes ❑ No

If yes, please list: ____________________

____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Ibuprofen
Y	N	Codeine	Y	N	Penicillin
Y	N	Anesthetics	Y	N	Latex
Y	N	Metals/jewelry	Y	N	Seasonal

Please list any other allergies you have:

____

Have you ever had any of the following:

Y N Abnormal Bleeding
Y N Anemia
Y N Artificial Joints/Heart Valves
Y N Asthma
Y N Arthritis
Y N Blood Transfusion
Y N Bone Disorders/Osteoporosis
Y N Cancer/Chemotherapy/Radiation Treatment
Y N Cold/Canker Sores
Y N Congenital Heart Defects
Y N Diabetes
Y N Difficulty Breathing
Y N Drug/Alcohol Abuse
Y N Epilepsy/Seizures/Fainting
Y N Fever Blisters/Herpes
Y N Frequent/Severe Headaches
Y N Heart Murmur
Y N Heart Disease/Surgery/Pacemaker
Y N Hepatitis
Y N High/Low Blood Pressure
Y N HIV/AIDS
Y N Hospitalization
Y N Kidney Disease
Y N Liver Disease
Y N Psychiatric Problems
Y N Rheumatic/Scarlet Fever
Y N Tonsils Removed? Age?

For woman only: are you pregnant? ❑ Yes ❑ No

PATIENT'S DENTAL INFORMATION:

Dentist's Name: ____________________

Date of last exam: ____________________

Dental work to be completed: ❑ Yes ❑ No

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

____

____

Have you consulted an orthodontist previously?	Y	N
Was orthodontic treatment provided?	Y	N
Are you fearful of having dental work done?	Y	N
Previous trauma to your teeth and/or face?	Y	N
Do you have a history of thumb/finger sucking?	Y	N
Do you have any missing adult teeth?	Y	N
Do you have any extra adult teeth?	Y	N
Do you have jaw joint clicking noises?	Y	N
Do you have jaw joint popping noises?	Y	N
Do you have difficulty opening wide?	Y	N
Does it hurt to open wide?	Y	N
Do you have any speech problems?	Y	N
Do you grind or clench your teeth at night?	Y	N
Do you breathe mostly through your mouth?	Y	N

How many times a day do you brush your teeth? ____________________

How many times a day do you floss your teeth? ____________________

Genetics and the pubertal growth spurt play an important role in orthodontics. Can you please provide us with the following information (if under 16 years of age):

I resemble my: ❑ Father ❑ Mother ❑ Both ❑ None

Are you adopted: ❑ Yes ❑ No

Boys: Has puberty been reached? ❑ Yes ❑ No

Girls: Has menstruation begun? ❑ Yes ❑ No

Whom may we thank for referring you?

____

How did you hear about our office?

____

PATIENT CONSENT:

I understand that the information I have provided is correct to the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in address and medical/dental 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

Date of Consultation: ____________________