WELCOME

We would like to welcome you to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. Thank you for your cooperation.

Patient Information

Name ____________________ ____________________ ________
Last First Middle Sex Marital Status

Address ____________________ ____________________ ________ ________
Street City State Zip

Birthdate ____________ (MM-DD-YYYY) E-mail ____________ Social Security# ____________ (999-99-9999)

Home Phone ____________ (999-999-9999) Cell Phone ____________ (999-999-9999) Work Phone ____________ (999-999-9999) ext. ________

Employer ____________ Occupation ____________ No. Years Employed ________

General Dentist ____________ Last Visited ____________

Who may we thank for referring you to our office ____________________

Spouse / Additional Contact Information

Name ____________________ ____________________ ________
Last First Middle Marital Status

Address ____________________ ____________________ ________ ________
Street City State Zip

Birthdate ____________ (MM-DD-YYYY) E-mail ____________ Relationship to Patient ____________

Home Phone ____________ (999-999-9999) Cell Phone ____________ (999-999-9999) Work Phone ____________ (999-999-9999) ext. ________

Employer ____________ Occupation ____________ No. Years Employed ________

Insurance Information

Policy Owner's Name ____________ Policy Owner's Social Security # ____________ (999-99-9999)

Policy Owner's Birthdate ____________ (MM-DD-YYYY) Relationship to Patient ____________

Policy Owner's Employer ____________ Employer's Address ____________

Insurance Company ____________ Group No. (plan, local, or policy) ____________

Insurance Co. Address ____________ Insurance Phone No. ____________

Secondary Insurance

Policy Owner's Name ____________ Policy Owner's Social Security # ____________ (999-99-9999)

Policy Owner's Birthdate ____________ (MM-DD-YYYY) Relationship to Patient ____________

Policy Owner's Employer ____________ Employer's Address ____________

Insurance Company ____________ Group No. (plan, local, or policy) ____________

Insurance Co. Address ____________ Insurance Phone No. ____________

Medical History

Are you under the care of a physician? ☐ Yes ☒ No If Yes, explain ____________________

Physician ____________________ Phone ____________ Last Visit ____________

Address ____

Are you pregnant ☐ Yes ☒ No If so how many weeks ____________

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

Have you ever been evaluated for orthodontic treatment? ____________________

Have you tonsils or adenoids been removed? ☐ Yes ☒ No

Have you ever experienced jaw joint pain/ discomfort (TMJ/TMD)? ☐ Yes ☒ No

Do you have any missing or extra permanent teeth? ☐ Yes ☒ No

Have you ever had an injury to : (select all that apply) ☐ Teeth ☐ Mouth ☐ Chin

Do you have speech problems? ☐ Yes ☒ No if Yes, explain ____________________

Do your gums bleed? ☐ Yes ☒ No Do you smoke? ☐ Yes ☒ No Do you like your smile? ☐ Yes ☒ No

Does/Have you ever had any of the following habits?

☐ Clenching/Grinding Teeth ☐ Lip Sucking/Biting ☐ Nail biting ☐ Prolonged Bottle/Pacifier ☐ Mouth Breather ☐ Tongue Thrusting ☐ Thumb/ Finger Sucking

Are you allergic to any of the following?

☐ Aspirin ☐ Erythromycin

☐ Codeine ☐ Penicillin

☐ Tetracycline ☐ Latex

☐ Any Metals/Plastics

Other Allergies/Sensitivites:

____

List all drugs you are currently taking

List any serious medical condition(s) treated

Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidences and it is my responsibility to inform this office of any changes in my medical status.
I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office.
I understand that where appropriate, credit bureau reports may be obtained.

Name of person filing out this form ____________________ Date ____________________