Account# ______________

C: ______ Family: ________

Welcome
to the Orthodontist

We would like to welcome you to our office. Our goal is to make every visit pleasant and educational. We strive to teach good oral care that will enable you to have a beautiful smile that lasts a lifetime.

Tell us about you

Todays Date: ____________

Name: ______________________________________
First Last Mid. Init. Mr. Mrs. Ms. Dr.

I prefer to be called: ______________________

Birthday: ______________ Age: ______ ☐ Male ☐ Female

Social Security #: ______________________

Home Address: ______________________

____
City State Zip

☐ Single ☐ Partnered ☐ Divorced
☐ Married ☐ Separated ☐ Widowed

Home #: ______________ Cell #: ______________

Work#: ______________ Ext: _____ DL #: __________

Email address: ______________________

Employer: ______________________

Address: ______________________

How long at current job: ______ Job title: ______________

When and where are the best times to reach you: ______________

____

Whom may we thank for refering you?: ______________

Other family members seen by us: ______________

General Dentist: ______________________

Date of last visit: ______________________

Spouse information

Name: ______________________________________
First Last Mid. Init.

Employer: ______________________

Work#: ______________ Ext: _____ SS #: __________

Birthday: ______________________

Person responsible for account

Name: ______________________ Relation: ____________

Billing address: ______________________

____
City State Zip

Home # ______________ Cell # ______________

Employer: ____________ Work # ____________ Ext. ______

SS #: ______________ DL #: ______________

Primary Orthodontic Insurance

Orthodontic coverage: ☐ Yes ☐ No

Insurance Co. name: ______________________

Insurance Co. address: ______________________

Insurance Co. phone #: ______________________

Group #: ______________ Id. #: ______________

Policy owners name: ______________________

Relationship to patient: ______________________

Policy owners birthday: ______________________

Policy owners employer: ______________________

Secondary Orthodontic Insurance

Orthodontic coverage: ☐ Yes ☐ No

Insurance Co. name: ______________________

Insurance Co. address: ______________________

Insurance Co. phone #: ______________________

Group #: ______________ Id. #: ______________

Policy owners name: ______________________

Relationship to patient: ______________________

Policy owners birthday: ______________________

Policy owners employer: ______________________

Medical history

Have you ever taken Bisphosphonates? ☐ Yes ☐ No

Have you ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No

Have you ever had any injuries to the face, mouth, teeth or chin? ☐ Yes ☐ No

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

Have you ever been informed of any missing or extra permanent teeth? ☐ Yes ☐ No

Have you ever had any pain/tenderness in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Do you have any speech problems? ☐ Yes ☐ No

Do you breath through your mouth? ☐ Yes ☐ No

If yes circle all that apply. While awake? While sleeping?

Do you smoke or use tobacco in any form? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

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

Are you currently pregnant? ☐ Yes ☐ No

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

Please explain: ____________________

Physicians name: ____________________

Phone #: __________ Date of last visit: __________

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

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

____

Please list all prescriptions and over the counter drugs you are currently taking: ____________________

____

Please list all medications/things you are allergic to: ____________________

____

Have you ever had any of the following medical problems?

Y N Abnormal bleeding	Y N Hemophilia
Y N Anemia	Y N Hepatitis
Y N Artificial bones/joints/valves	Y N High/low blood pressure
Y N Asthma/Arthritis	Y N HIV+/AIDS
Y N Blood transfusion	Y N Hospitalized for anything
Y N Cancer/chemotherapy	Y N Kidney problems
Y N Congenial heart defect	Y N Mitral valve prolapse
Y N Diabetes	Y N Psychiatric problems
Y N Difficulty breathing	Y N Radiation treatment
Y N Drug/alcohol abuse	Y N Rheumatic/Scarlet Fever
Y N Emphysema	Y N Severe/frequent headaches
Y N Epilepsy/seizers/fainting	Y N Shingles
Y N Fever blisters/Herpes	Y N Sickle cell disease/traits
Y N Glaucoma	Y N Sinus problems
Y N Heart attack/stroke	Y N Tuberculosis (TB)
Y N Heart murmur	Y N Ulcers/Colitis
Y N Heart surgery/pacemaker	Y N Venereal disease

Please list any serious medical conditions that you have or suffered from:

____

____

Relative or neighbor not living with you:

Name: ____________________ Address: ____________________

City: ____________________ State: __________ Zip: __________ Phone # __________

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 orthodontic staff to perform any necessary orthodontic services that I may need during diagnosis and treatment with my informed consent.

____
Signature Date

This office reserves the right to verify the credit status of the potential patients and/or parents of the patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office.

____
Signature Date

____
Signature Date

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