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

Last Name: _____ First Name: _____ Middle: _____Sex: _____

Address: _____ _____ _____ _____
Street City State Zip

Birthdate: _____ Email: _____ Social Security _____

General Dentist: _____ Last Visited: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Spouse's Employer: _____ Occupation: _____ Number of years: _____

Whom may we thank for referring you to our office? _____

SPOUSE INFORMATION

Name: _____ _____ Birthdate: _____
Last First

Spouse's Cell # or preferred Contact #: _____ Spouse's e-mail _____

Spouse's Employer: _____ Occupation: _____ Number of years: _____

Dental / Orthodontic Insurance Information

If you have an insurance card, you may give to the front desk to gather most of the following information.

Policy Holder's Name: _____ Policy Holder's Employer: _____

Insurance Company: _____ Insurance Company Phone #: _____

Insurance Company's Address: _____ _____ _____ _____
Street City State Zip

Group / Policy #: _____ Policy Holder's Social Security #: _____-_____-_____

Secondary Insurance

Policy Holder's Name: _____ Policy Holder's Employer: _____

Insurance Company: _____ Insurance Company Phone #: _____

Insurance Company's Address: _____ _____ _____ _____
Street City State Zip

Group / Policy #: _____ Policy Holder's Social Security #: _____-_____-_____

Medical History

Medical Physician: _____ Phone: _____ Last Visit: _____

Are you currently under the care of a physician? Yes_____ No_____ If yes, please explain:_____

Are you pregnant? Yes _____ No _____ If so, how many weeks? _____

What are the main concerns that you would like orthodontic treatment to accomplish? _____

Have you ever been evaluated for orthodontic treatment? Yes _____ No _____

Have your 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: (circle all that apply) Teeth Mouth Chin

Have you experienced any of the following habits? (Circle all that apply) Lip Sucking Nail biting Mouth Breather Clenching/Grinding Teeth Tongue Thrusting Thumb/Finger Sucking

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 _____

Are you allergic to any of the following? (Circle all that apply) Aspirin Codeine Erythromycin

Penicillin Tetracycline Latex Any Metals / Plastics Other: _____

Please list any drugs/medications you are currently taking: _____

_____

Please list any serious medical conditions being 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 confidence and it is my responsibility to inform this office of any changes in my child's 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 filling out this form: _____ Date: _____