WELCOME
TO THE ORTHODONTIST

The benefits of a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset.

Please fill out this form completely. The better we communicate, the better we can care for you.

1 About You

Today's Date:_____

Email Address: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: ___/___/___ Age:_____ SS #: _____

Home Address: _____
APT/CONDO #

_____
STATE ZIP

How long? _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (____) _____ Pager / Other #:_____

Wk #: (____) _____ Ext:____ DL #:_____

Employer: _____

Employer's Address: _____

How long there?_____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

General Dentist: _____

Last Visit Date: _____

2 Spouse Information

His / Her Name:_____

Employer: _____ How long:_____

Wk #: (____) _____ Ext:____ SS #:_____

Birthdate: ___/___/___

Person Responsible for Account: _____

Wk #: (____) _____ Ext:____ Hm #: (____)_____

Billing Address: _____

Relation: _____ SS #:_____

Employer: _____ DL #:_____

3 Orthodontic Insurance

Primary

Orthodontic Coverage: ☐ Yes ☐ No Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name _____ Relation:_____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer:_____

Secondary

Orthodontic Coverage: ☐ Yes ☐ No Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name _____ Relation:_____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer:_____

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: _____ **Relation:**_____

Wk #: (____) _____ Hm #: (____)_____

How did you hear about our office?
(Please mark "all" that apply)

☐ Dentist ☐ Location/Sign ☐ Internet ☐ Family Friend
☐ Newspaper ☐ Phone Book ☐ Other_____

4 Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name:_____

Phone #: (____) _____ Date of last visit:_____

CONTINUED ON BACK

4 Medical History *continued*

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

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

Please explain: _____

Are you taking any prescription / over-the-counter drugs? ☐ Yes ☐ No

Please list each one: _____

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or 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 Any Reason
Y N	Cancer / Chemotherapy	Y N	Kidney Problems
Y N	Congenital 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 / Seizures / 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 condition(s) that you have ever had:

_____

Are you allergic to any of the following?

Y N	Aspirin	Y N	Dental Anesthetics	Y N	Penicillin
Y N	Any Metals/Plastics	Y N	Erythromycin	Y N	Tetracycline
Y N	Codeine	Y N	Latex	Y N	Other

Please list any other drugs/materials that you are allergic to: _____

_____

5 Dental History

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

_____

_____

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

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

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ/TMDJ)? ☐ Yes ☐ No

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

Do you like your smile? ☐ Yes ☐ No Gums ever bleed? ☐ Yes ☐ No

Have you ever had an injury to your: Mouth Teeth Chin (Please Circle)

Do you generally breathe through your mouth? ☐ Yes ☐ No

If yes, please circle: While Awake? While Asleep?

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

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Have you ever taken Phen-Fen? ☐ Yes ☐ No

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

I

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 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

!

Thank you for filling out this form completely

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

Signature Date

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 (otherwise payable to me) directly to this office.

Signature Date

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

_____

_____

_____

_____

WELCOME
TO THE ORTHODONTIST

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

1 Tell Us About Your Child

Today's Date: ____/____/____ ☐ Male ☐ Female

Child's Name:: _____
LAST FIRST MI

Nickname: _____ Birthdate: _____

School: _____ Grade: _____

Hobbies / Sports: _____

Child's Home #: (____) _____

Child's Home Address: _____
APT/CONDO #

_____
CITY STATE ZIP

How long? _____

E-Mail Address: _____

2 Who Is Accompanying Your Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we Thank for referring you? _____

List brothers / sisters with age: _____

_____

General Dentist: _____

Last Visit Date: _____

Parent's Marital Status: ☐ Single ☐ Widowed ☐ Married ☐ Divorced ☐ Separated

3 ☐ Mother's Information: ☐ Step Mother ☐ Guardian

Name: _____ Birthdate: _____

Email Address: _____

Cell #: (____) _____ Hm #: (____) _____

Employer: _____ How long? _____

Wk #: (___) _____

SS #: _____ DL #: _____

☐ Father's Information: ☐ Step Father ☐ Guardian

Name: _____ Birthdate: _____

Email Address: _____

Cell #: (____) _____ Hm #: (____) _____

Employer: _____ How long? _____

Wk #: (___) _____

SS #: _____ DL #: _____

4 Person Responsible For Account

Name: _____ Relation: _____

Billing Address _____

_____
CITY STATE ZIP

Previous Address: _____

_____
CITY STATE ZIP

Hm #: (____) _____ DL #: _____

Employer: _____

Wk #: (____) _____ Ext: ____ SS #: _____

Who is responsible for making appointments?

Name: _____

Wk #: (____) _____ Ext: ____ Hm #: (____) _____

Neighbor or Relative not living with you.

Name: _____ Phone: (____) _____

Address: _____

_____
CITY STATE ZIP

5 Primary Insurance

Dental Coverage? ☐ Yes ☐ No Ortho Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ___/___/___ SS #: _____

Policy Owner's Employer: _____

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No Ortho Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ___/___/___ SS #: _____

Policy Owner's Employer: _____

CONTINUED ON BACK

6

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

_____

_____

Has your child ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No

Have there been any injuries to the face, mouth, teeth or chin? ☐ Yes ☐ No

List any musical instruments played: _____

Have adenoids or tonsils been removed? ☐ Yes ☐ No

Has your child been informed of any missing or extra permanent teeth? ☐ Yes ☐ No

Has your child ever had any pain / tenderness in his / her jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Does your child brush his / her teeth daily? ☐ Yes ☐ No

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

Child's Physician: _____

Phone #: (____) _____ Date of Last Visit: _____

Is your child currently under the care of a physician? ☐ Yes ☐ No

Has puberty begun? ☐ Yes ☐ No

Has menstruation begun? (Girls) ☐ Yes ☐ No

Has your child ever taken Phen-Fen? ☐ Yes ☐ No

(Also known as Redux or Pondimin) If yes, when? _____

Please describe your child's current physical health:

☐ Good ☐ Fair ☐ Poor

Please list all drugs that your child is currently taking: _____

_____

Please list all drugs / things that your child is allergic to: _____

_____

7

Has your child ever had any of the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Handicaps / Disabilities
Y	N	ADD / ADHD	Y	N	Hearing Impairment
Y	N	Allergies to any Drugs	Y	N	Heart Murmur
Y	N	Allergies to Latex / Metals	Y	N	Hemophilia
Y	N	Allergies to Plastic	Y	N	Hepatitis
Y	N	Any Hospital Stays	Y	N	HIV+ / AIDS
Y	N	Any Operations	Y	N	Kidney Problems
Y	N	Artificial Bones / Joints / Valves	Y	N	Liver Problems
Y	N	Asthma	Y	N	Lupus
Y	N	Cancer	Y	N	Rheumatic / Scarlet Fever
Y	N	Congenital Heart Defect	Y	N	Sickle Cell Disease / Traits
Y	N	Convulsions / Epilepsy	Y	N	Tuberculosis (TB)
Y	N	Diabetes			

Please discuss any medical problems that your child has had:

_____

_____

_____

8

Does / did your child have any of the following habits?

Y	N	Clenching / Grinding Teeth	Y	N	Nursing Bottle
Y	N	Lip Sucking / Biting	Y	N	Speech Problems
Y	N	Mouth Breather	Y	N	Thumb / Finger Sucking
Y	N	Nail Biting	Y	N	Tongue Thrust

Was your child breast fed? Y N

How did you hear about our office? (Please mark "all" that apply)

☐ Dentist ☐ Location/Sign ☐ Internet ☐ Family Friend

☐ Newspaper ☐ Phone Book ☐ Other _____

9

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need. If this office accepts insurance, I assign directly to Dr. all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

My method of payment will be: _____

_____ _____

Signature Date

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

_____ _____

Signature of parent or guardian Date

The Parent or Guardian who accompanies the child is responsible for payment.

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.

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent / guardian named herein.

Doctor's Comments: Initials: _____ Date: _____

_____

_____

_____