1 Tell Us About You

Today's Date:____________________

Your Name:____
Last First M. Ini.

I prefer to be called: ____________________ ❑ Female ❑ Male

Birthdate: ______________________ Age: ________________

SSN:____

Hobbies/Sports: ______________________________________

Home#: ( )______________ Work#: ( )______________

Cell #: ( )____

Email address: _______________________________________

Home Address:_______________________________________

____
City State Zip

❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑Separated

Whom may we thank for referring you? ________________

Other family members seen by us:___________________

____

General Dentist:_____________________________________

Last Exam Date:___________________Any cavities?_______

Any proposed treatment? _____________________________

2 Spouse Information

Name:____

Wk#:( ) ______________________ Ext.________________

Cell#:( )____

3 Person Responsible For Account

Name:________________________ Relation:________________

Billing Address:_____________________________________

____
City State Zip

Hm#: ( )__________________ TDL#:____________________

Employer:____

Wk#: ( )________________________________Ext.________

SSN:____

Birthdate:____

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

His/Her Name: ______________________________________

Relation:_________________ Work# __________________

Home#__________________ Cell#___________________

4 Dental Insurance

Orthodontic coverage? ❑Yes ❑ No ❑ Unsure

Insurance Co. Name:_______________________________

Insurance Co. Address:_____________________________

Insurance Co. Phone#: ( )__________________________

Group# (Plan, local, or Policy #):_____________________

Policy Owner's Name:_______________________________

Relationship to Patient:____________________________

Policy Owner's DOB:________________________________

Policy Owner's SSN:________________________________

Policy Owner's Employer: ___________________________

Secondary Dental Insurance

Orthodontic coverage? ❑Yes ❑ No ❑ Unsure

Insurance Co. Name:_______________________________

Insurance Co. Address:_____________________________

Insurance Co. Phone#: ( )__________________________

Group# (Plan, local, or Policy #):_____________________

Policy Owner's Name:_______________________________

Relationship to Patient:____________________________

Policy Owner's DOB:________________________________

Policy Owner's SSN:________________________________

Policy Owner's Employer: ___________________________

5 Dental History

Have you ever had a serious/difficult problem associated with any previous dental work? Y N

Your current dental health is:

❑ Good ❑ Fair ❑ Poor

Do your gums bleed every time you brush? Y N

Do you generally breathe through your mouth? Y N

Awake? Y N During Sleep? Y N

Have there been any injuries to the face, mouth, teeth or chin? Y N

Have adenoids or tonsils been removed? Y N

Have you been informed of any missing or extra permanent teeth? Y N

Have you ever had any pain / tenderness in your jaw joint (TMJ/TMD)? Y N

Y N Clenching/Grinding Y N Food impaction
Y N Lip Sucking/Biting Y N Pain around ear
Y N Bad Breath Y N Burning Tongue
Y N Nail/Cheek Biting Y N Tongue Thrust
Y N Use Dental Floss Y N Water Jet Device
Y N Fluoride supplements
Y N Teeth senstive to cold,heat, sweets or pressure
Y N Swelling or lumps in mouth
Y N Periodontal Treatment
Y N Cigarette/Tobacco use

6 WHAT WOULD YOU LIKE ORTHODONTICS TO ACCOMPLISH?

____

____

____

Have you ever been evaluated or had orthodontic treatment before? Y N

Do you like your smile? Y N

Did your regular dentist recommend treatment? Y N

Do you plan to whiten your teeth after treatment? Y N

Do you plan to have cosmetic bonding/veneers? Y N

7 MEDICAL HISTORY

Physician: ______________________________

Phone#: (   )______________________________

Date of Last Visit:______________________________

Are you currently under the care of a physician? Y N

Please describe your current physical health:

❑ Good ❑ Fair ❑ Poor

Please list all drugs that you are currently taking:

____

____

____

Are you allergic to any of the following?:

Y N Aspirin Y N Codeine Y N Any Metal/Plastic

Y N Penicillin Y N **Latex** Y N **Nickel**

Other drugs:

____

____

Hospitalizations:

____

____

Women:

Are you currently pregnant? Y N

If yes, due date? ______________________________

8 HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS:

Y N Abnormal Bleeding
Y N Malignancies
Y N Allergic to Plastics
Y N Any Hospital Stays
Y N Any Operations
Y N Arthritis
Y N Artificial Valves
Y N Asthma
Y N Hay Fever/Allergies
Y N Cancer/Chemotherapy
Y N Congenital Heart Defect
Y N Glaucoma
Y N Diabetes
Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Mitral Valve Prolapse
Y N Heart Ailments
Y N Anemia/Hemophilia
Y N Heart Attack
Y N High/Low Blood Pressure
Y N Kidney/Liver Problems
Y N Rheumatic/Scarlet Fever
Y N Psychiatric Care
Y N Pregnancy
Y N Thyroid Issues
Y N Epilepsy/Seizures
Y N Radiation Treatment
Y N Joint Replacement
Y N Stroke
Y N Difficulty Breathing
Y N Eye Disorders
Y N Ulcers/Colitis
Y N Veneral Disease
Y N Drug Abuse
Y N Emphysema
Y N Tuberculosis (TB)
Y N Fever Blisters
Y N Hepatitis
Y N Pacemaker
Y N Headaches
Y N Migraines
Y N Shingles
Y N Sinus Problems
Y N HIV +/ AIDS

Is there anything not listed above that you feel that we need to be informed about? Y N

If Yes, Please describe: ______________________________

____

____

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 my medical status. I authorize the dental staff to perform the necessary dental services I may need.

____

Signature Date

I verbally retrieved the medical / dental information above with the patient named herein.

Doctor's Comments Initials: ____________ Date: ____________

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

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