Welcome

Patient Information

Name ____________________ Soc. Sec. # ____________

Last Name , First Name Middle Initial

Address ____________________ Home Phone ____________

City ____________ State ________ Zip ________ E-mail ____________

Sex ○ M ○ F Age ________ Birthdate ____________ ○Single ○Married ○Widowed ○Separated ○Divorce

Patient Employed By ____________________ Occupation ____________

Business Address ____________________ Business Phone ____________

Whom may we thank for referring you? ____________________

Notify incase of Emergency ____________________ Home Phone ____________

Work Phone ____________________ Cell Phone ____________

Business E-Mail ____________________

Primary Insurance

Person Responsible for Account ____________________

Last Name First Name Middle Initial

Relation to Patient ____________ Birthdate ____________ Soc. Sec. # ____________

Address (if different from above) ____________________ Home Phone ____________

City ____________ State ________ Zip ________

Cell Phone ____________ E-mail ____________________

Person Responsible Employed By ____________________ Occupation ____________

Business Address ____________________ Business Phone ____________

Business E-mail ____________________

Insurance Company ____________________ Phone ____________

Contract # ____________ Group # ____________ Subscriber's # ____________

Name(s) of other dependants under this plan ____________________

Additional Insurance

Is Patient covered by additional insurance? ○ Yes ○ No

Subscriber's Name ____________ Relation to Patient ____________ Birthdate ____________

Address (if different) ____________________ Soc. Sec. # ____________

City ____________ State ________ Zip ________ Home Phone ____________

Cell Phone ____________ Business Phone ____________

Subscriber Employed By ____________________ Occupation ____________

Business Address ____________________ Business Phone ____________

Business E-mail ____________________

Insurance Company ____________________ Phone ____________

Contract # ____________ Group # ____________ Subscriber's # ____________

Please Complete Both Sides

Welcome

Dental History

What would you like us to do today? ______________________________ Are you in dental discomfort today? ___________________

Current Dentist _________________________________ Address ______________________________ Phone ____________________

Dentist's E-mail ____ Date of last dental visit __________ Date of last x-rays __________

Check **Y** for "Yes" or **N** for "No" if you have or have not had the following:

○Y○N Bad breath
○Y○N Food collection between teeth
○Y○N Periodontal treatment
○Y○N Sensitivity to sweets
○Y○N Bleeding gums
○Y○N Grinding or clenching teeth
○Y ○N Sensitivity to cold
○Y ○N Sensitivity when biting
○Y ○N Clicking or popping jaw
○Y ○N Loose teeth or broken filings
○Y ○N Sensitivity to hot
○Y ○N Sores or growths in mouth

How often do you brush? ________________________ How often do you floss? ______________________

How do you feel about your teeth/smile? ____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ○Y ○N

Medical History

Physician's name ______________________________ Address ______________________________ Phone _____________________

Physician's E-mail ____

Date of last visit ____________ Have you ever had any serious illnesses/operations? If yes, Describe__________________________

Are you currently under physician care? ○Y ○N If yes, describe ____

Have you ever had a blood transfusion? ○Y ○N If yes, give approximate date(s): ____

Have you ever taken Fen-Phen?Redux? ○Y ○N

Women: Are you pregnant? ○Y ○N Nursing? ○Y ○N Taking birth control pills? ○Y ○N

Check **Y** for "Yes" or **N** for "No" if you have or have not had the following:

○Y ○N AIDS/HIV Positive
○Y ○N Anaphylaxis
○Y ○N Anemia
○Y ○N Arthritim, Rheumatism
○Y ○N Artificial heart valves
○Y ○N Artificial joints
○Y ○N Asthma
○Y ○N Atopic (allergy prone)
○Y ○N Back problems
○Y ○N Blood disease
○Y ○N Cancer
○Y ○N Chemical dependency
○Y ○N Chemotherapy
○Y ○N Circulatory problems
○Y ○N Cortisone treatments
○Y ○N Cough, persistent
○Y ○N Diabetes
○Y ○N Epilepsy
○Y ○N Fainting
○Y ○N Food allergies
○Y ○N Glaucoma
○Y ○N Headaches
○Y ○N Heart murmur
○Y ○N Heart problems
Describe _____________________
○Y ○N Hemophilia/Abnormal bleeding
○Y ○N Herpes
○Y ○N Hepatitis
○Y ○N High Blood pressure
○Y ○N Jaw pain
○Y ○N Kidney disease/malfunction
○Y ○N Liver disease
○Y ○N Material allergies (latex, wool, metal, chemicals)
○Y ○N Mitral valve prolapse
○Y ○N Nervous problems
○Y ○N Pacemaker/Heart surgery
○Y ○N Psychiatric care
○Y ○N Rapid weight gain/loss
○Y ○N Radiation treatment
○Y ○N Rheumatic fever
○Y ○N Scarlet fever
○Y ○N Shingles
○Y ○N Shortness of breath
○Y ○N Skin rash
○Y ○N Spina bifida
○Y ○N Stroke
○Y ○N Surgical implant
○Y ○N Swelling of feet/ankles
○Y ○N Thyroid disease/malfunction
○Y ○N Tobacco habit
○Y ○N Tonsilitis
○Y ○N Tuberculosis
○Y ○N Ulcer/Colitis
○Y ○N Venereal disease

Any allgeries to nickel? ○Y ○N

List medications currently taking, if any:

____
____
____

Any allgeries to latex? ○Y ○N

List allergies, if any:

____
____
____

Welcome

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful orthodontic treatment. If there is any change in my address, phone numbers, dentist or medical status, I will inform the staff and orthodontist.

I authorize the insurance company to pay the orthodontist or orthodontic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. _______
initials

I authorize the orthodontist to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. ____________
Initials

Signature ____ Date ______________________