Welcome

To the Orthodontist

Today's Date:

Name:

_____
Last First MI

I prefer to be called: _____ □ Male □ Female

Birthdate: _____/_____/_____ Age: _____

SS #: _____

Home Address:

_____

_____
City State Zip

Home #: (____)_____ Cell #: (____)_____

Work #: (____)_____ Ext: ____

□ Single □ Married □ Widowed □ Divorced □ Separated

E-Mail Address: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

How Long There? _____ Occupation: _____

Where & When are best times to reach you? _____

_____

Spouse Name: _____

Employer: _____

Work #: (_____)_____ Cell#: (____)_____

Birthdate: _____/_____/_____ SS#: _____

Relative or Friend not living with you:

Name: _____

Phone #: (_____)_____Work #: (_____)_____

General Dentist: _____

Last Visit Date: _____

Whom may we thank for referring you?

_____

Other family members seen by us:

_____

Primary Insurance

Orthodontic Coverage? □Yes □No

Insurance Co. Name: _____

Insurance Address: _____

_____

Insurance Phone: (_____)_____

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

Insured's Name: _____ Relation: _____

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

Insured's Employer: _____

Employer's Address: _____

_____
City State Zip

Secondary Insurance

Orthodontic Coverage? □Yes □No

Insurance Co. Name: _____

Insurance Address: _____

_____

Insurance Phone: (_____)_____

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

Insured's Name: _____ Relation: _____

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

Insured's Employer: _____

Employer's Address: _____

_____
City State Zip

Dental & Medical History

What are the main concerns you would like Orthodontics to accomplish? _____

_____

_____

Are you happy with the way your smile looks? □Yes □No

If not, what would you change? _____

_____

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

Have there been 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

Do you have any speech problems? □Yes □No

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

Do you still have wisdom teeth? □Yes □No

Do you ever have any pain/tenderness in your jaw joint (TMJ/TMD)? □Yes □No

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

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

Please describe your current dental health:

□ Good □ Fair □ Poor

Physician's Name: _____

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

Please describe your current physical health:

□ Good □ Fair □ Poor

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

Please Explain: _____

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

Have you had any metal rods, pins or implants? □Yes □No

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

Please list each one: _____

For Women: Are you taking birth control pills? □Yes □No

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

Are you nursing? □Yes □No

Have you ever had any of the following medical problems?

□Yes □No	Abnormal Bleeding/ Hemophilia	□Yes □No	Herpes/ Fever Blisters
□Yes □No	AIDS	□Yes □No	High Blood Pressure
□Yes □No	Alcohol/Drug Abuse	□Yes □No	HIV
□Yes □No	Anemia	□Yes □No	Hospitalized
□Yes □No	Arthritis	□Yes □No	Kidney Problems
□Yes □No	Artificial Bones/ Joints/Valves	□Yes □No	Liver Disease
□Yes □No	Asthma	□Yes □No	Low Blood Pressure
□Yes □No	Blood Transfusion	□Yes □No	Lupus
□Yes □No	Cancer/Chemotherapy	□Yes □No	Mitral Valve Prolapse
□Yes □No	Colitis	□Yes □No	Pacemaker
□Yes □No	Congenital Heart Defect	□Yes □No	Psychiatric Problems
□Yes □No	Diabetes	□Yes □No	Radiation Treatment
□Yes □No	Difficulty Breathing	□Yes □No	RheumaticFever / Scarlet Fever
□Yes □No	Emphysema	□Yes □No	Seizures
□Yes □No	Epilepsy	□Yes □No	Shingles
□Yes □No	Fainting Spells	□Yes □No	Sickle Cell Disease/ Traits
□Yes □No	Frequent Headaches	□Yes □No	Sinus Problems
□Yes □No	Glaucoma	□Yes □No	Stroke
□Yes □No	Hay Fever	□Yes □No	Thyroid Problems
□Yes □No	Heart Attack/Surgery	□Yes □No	Tuberculosis (TB)
□Yes □No	Heart Murmur	□Yes □No	Ulcers
□Yes □No	Hepatitis	□Yes □No	Venereal Disease

Please discuss any serious medical problems you have ever had:

_____

_____

_____

Are you allergic to any of the following?

□Yes □No Aspirin
□Yes □No Codeine
□Yes □No Dental Anesthetics
□Yes □No Erythromycin
□Yes □No Jewelry/Metals
□Yes □No Latex
□Yes □No Penicillin
□Yes □No Tetracycline
□Yes □No Other

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

_____

_____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental/orthodontic services I may need.

_____

Signature of Parent or Guardian Date