



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 _____ School attending _____
 Hobbies _____
 Favorite book(s)/movie(s) _____ Favorite subject(s) _____
 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:

- | | | | |
|---|---|---|--|
| <input type="radio"/> Y <input type="radio"/> N Bad breath | <input type="radio"/> Y <input type="radio"/> N Sensitivity to sweets | <input type="radio"/> Y <input type="radio"/> N Sensitivity to cold | <input type="radio"/> Y <input type="radio"/> N Loose teeth or broken fillings |
| <input type="radio"/> Y <input type="radio"/> N Food collection between teeth | <input type="radio"/> Y <input type="radio"/> N Bleeding gums | <input type="radio"/> Y <input type="radio"/> N Sensitivity when biting | <input type="radio"/> Y <input type="radio"/> N Sensitivity to hot |
| <input type="radio"/> Y <input type="radio"/> N Periodontal treatment | <input type="radio"/> Y <input type="radio"/> N Grinding or clenching teeth | <input type="radio"/> Y <input type="radio"/> N Clicking or popping jaw | <input type="radio"/> Y <input type="radio"/> 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:

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

Any allgeries to nickel? Y N

Any allgeries to latex? Y N

List medications currently taking, if any:

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 _____