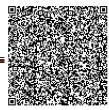


Welcome



Patient Information

Name			Soc.	Sec. #	
Last Name	Last Name First Name		Middle Initial Home Phone		
City					
Sex OM OF Age					
_			_		
Hobbies Favorite book(s)/movie(s)				act(s)	
Whom may we thank for referring					
•					
		Home Phone Cell Phone			
Business E-Maii					
		Primary I	nsurance		
Person Responsible for Account					
Deletien to Detient		st Name		First Name	Middle Initial
Relation to Patient					
Address (if different from above					
City					
Cell Phone					
Person Responsible Employed B					
Business Address					
Business E-mail					
			Phone		
			Subscriber's #		
Name(s) of other dependants und	der this plan				
		Additional	Insurance		
Is Patient covered by additional	incuranca? ∩ Vac (O No			
Subscriber's Name			to Dationt	Dinth data	
Address (if different)					
Call Phone					
Cell Phone					
		Occupation Business Phone			
Business E-mail					
Insurance Company					
Contract #	Group	#		Subscriber's #	



Welcome



Dental History

·		ess Phone			
	"No" if you have or have not had the				
OYON Bad breath OYON Food collection between teeth OYON Periodontal treatment	YON Sensitivity to sweetsYON Bleeding gumsYON Grinding or clenching teeth	Y O N Sensitivity to coldY O N Sensitivity when bitingY O 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 yo	ou brush?	How often do you floss?			
How do you feel about your	teeth/smile?				
Have you ever experienced a	nn adverse reaction during or in conju	nction with a medical or dental pro	ocedure? OY ON		
	Medica	l History			
Physician's name	Add	ress F	hone		
	Have you ever had any serious i				
Are you currently under phys	sician care? OY ON If yes, describe	·			
Have you ever had a blood tr	ransfusion? OY ON If yes, give appro	oximate date(s):			
Have you ever taken Fen-Pho		(
•	OY ON Nursing? OY ON Taking bi	rth control pills? OV ON			
	"No" if you have or have not had the	•			
○Y ○N AIDS/HIV Positive	○ Y ○ N Cortisone treatments	○Y ○N High Blood pressure	○Y ○N Shingles		
○Y ○N Anaphylaxis	○ Y ○ N Cough, persistent	○Y ○N Jaw pain	○ Y ○ N Shortness of breath		
○Y ○N Anemia	○Y ○N Diabetes	○ Y ○ N Kidney disease/malfunction	○ Y ○ N Skin rash		
○Y ○N Arthritim, Rheumatism	○Y ○N Epilepsy	○Y ○N Liver disease	○Y ○N Spina bifida		
○ Y ○ N Artificial heart valves	○ Y ○ N Fainting	○ Y ○ N Material allergies (latex, wool,	○Y ○N Stroke		
○Y ○N Artificial joints	○Y ○N Food allergies	metal, chemicals)			
○Y ○N Asthma	∘Y ∘N Glaucoma	○ Y ○ N Mitral valve prolapse	○ Y ○ N Swelling of feet/ankles		
Y ○ N Atopic (allergy prone)	○ Y ○ N Headaches	○ Y ○ N Nervous problems	○ Y ○ N Thyroid disease/malfunction		
○Y ○N Back problems	○Y ○N Heart murmur	○Y ○N Pacemaker/Heart surgery	○ Y ○ N Tobacco habit		
○Y ○N Blood disease	○ Y ○ N Heart problems	○ Y ○ N Psychiatric care	○ Y ○ N Tonsilitis		
○Y ○N Cancer	Describe	○ Y ○ N Rapid weight gain/loss	○ Y ○ N Tuberculosis		
○ Y ○ N Chemical dependency	○ Y ○ N Hemophilia/Abnormal bleeding	○ Y ○ N Radiation treatment	○ Y ○ N Ulcer/Colitis		
○Y ○N Chemotherapy	○Y ○N Herpes	○ Y ○ N Rheumatic fever	○ Y ○ N Venereal disease		
○ Y ○ N Circulatory problems	○Y ○N Hepatitis	○ Y ○ N Scarlet fever			
Any allgeries to nickel?	\circ Y \circ N	Any allgeries to latex?	\circ Y \circ 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 orthogonal	odontic group all insurance benefits	otherwise
payable to me for services rendered. I authorize the use of this sig	gnature on all insurance submissions	·initials
I authorize the orthodontist to release all information necessary to	to secure payment of benefits. I unde	rstand that
I am financially responsible for all charges whether or i	not paid by insurance	_
Signature	Date	