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Member American Association of Orthodontists

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DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

Welcome

We would like to welcome you to our office. Our goal is to make every visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable you to have a beautiful smile that lasts a lifetime.

PATIENT INFORMATION: Today's Date: _____

Name: _____
Last First MI

Nickname: _____ ❑ Male ❑ Female

Birthdate: ____/____/____ Age:_____

School: _____ Grade: _____

Hobbies/Sports: _____

Musical Instruments:_____

Home Phone: (_____)_____

Home Address: _____

_____
CITY STATE ZIP

How did you hear about our office? _____

_____

Previous / Present Dentist: _____
(Please Circle)

Last visit date: _____

Other family members seen by us with Birthdate:

Name	Birthdate
_____	____/____/____
_____	____/____/____
_____	____/____/____

Who is responsible for account?

Name: _____

Parent Information:

Who is accompanying you today? ❑ Mom ❑ Dad ❑ Other

_____

Does this person have legal custody of you? ❑ Yes ❑ No

Parent's Marital Status: (Please Circle) Single Widowed Married Remarried Divorced Separated

Mother's Information: ❑ Step Mother ❑ Guardian

Name: _____ Birthdate: ____/____/____

Wk Phone: (____)_____ Cell: (____)_____

Email: _____

Employer: _____

Father's Information: ❑ Step Father ❑ Guardian

Name: _____ Birthdate: ____/____/____

Wk Phone: (____)_____ Cell: (____)_____

Email: _____

Employer: _____

Have you ever been seen by another orthodontist?

Orthodontist Name: _____

Have you had previous orthodontic treatment?

❑ Yes ❑ No _____

Who do we thank for referring you to our office? _____

How do you want to be reminded of appointments?

COMPLETE ONE ONLY

Email _____

Voicemail_____ Text Message_____

Primary Dental Insurance:

Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
CITY STATE ZIP

Insurance Co. Phone #: (____)_____

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

Policy Owner's Name: _____

Relationship to Policy Owner: _____

Policy Owner's Birthdate: ____/____/____ SS#: _____

Secondary Dental Insurance:

Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
CITY STATE ZIP

Insurance Co. Phone #: (____)_____

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

Policy Owner's Name: _____

Relationship to Policy Owner: _____

Policy Owner's Birthdate: ____/____/____ SS#: _____

Office Use: %_____ LTM _____ USED_____ %_____ LTM _____ USED_____

Why have you come to the dentist today and/or What are the main concerns that you would like orthodontics to accomplish?

_____

_____

_____

Are immunizations current? ❑ Yes ❑ No

Have you experienced problems with previous dental work? ❑ Yes ❑ No

Is your water fluoridated? ❑ Yes ❑ No

Are you taking fluoridated supplements? ❑ Yes ❑ No

Have you ever had any pain/ tenderness in your jaw joint (TMJ / TMD)? ❑ Yes ❑ No

Do you brush your teeth daily? ❑ Yes ❑ No

Floss your teeth daily? ❑ Yes ❑ No

Do your gums bleed? ❑ Yes ❑ No

Do you need to be premedicated before dental work? ❑ Yes ❑ No

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

Physician's Name: _____

Phone #: (_____) _____ Date of last visit: _____

Please describe your current physical health:

❑ Good ❑ Fair ❑ Poor

Please list all drugs that you are currently taking: _____

_____

_____

Important Growth Predictors:

Has puberty begun? (Boys) ❑ Yes ❑ No

Has your voice changed? ❑ Yes ❑ No

Date menstruation began? (Girls) _____

Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No ❑ Unsure Week #: _____

Are you nursing? ❑ Yes ❑ No

Have there been any injuries to your face, mouth, teeth or chin? ❑ Yes ❑ No

Have adenoids or tonsils been removed? ❑ Yes ❑ No

Have you been informed of any missing or extra permanent teeth? ❑ Yes ❑ No

Do you still have your wisdom teeth? ❑ Yes ❑ No

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Y N Aspirin
Y N Any Metal
Y N Plastic
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Latex
Y N Penicillin
Y N Tetracycline
Y N Other

Please list any other Allergies that you have _____

_____

DID/DO YOU HAVE ANY OF THE FOLLOWING HABITS?

Y N Nursing Bottle Habits
Y N Speech Problems
Y N Thumb / Finger Sucking
Y N Tongue Thrust
Y N Clenching / Grinding Teeth
Y N Lip Sucking / Biting
Y N Mouth Breather
Y N Nail Biting
Y N Any Tension Headaches?
Y N Used Pacifier?

HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

Y N Abnormal Bleeding
Y N Anemia
Y N Any Hospital Stays
Y N Asthma
Y N Cancer
Y N Chicken Pox
Y N Congenital Heart Defect
Y N Convulsions / Epilepsy
Y N Diabetes
Y N Exposed to HIV, but Neg. or drug controlled
Y N Handicaps / Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis
Y N Hives
Y N HIV+ / AIDS
Y N Kidney Problems
Y N Liver Problems
Y N Measles
Y N Mononucleosis
Y N Mitral Valve Prolapse
Y N Rheumatic / Scarlet Fever
Y N Skin Rash
Y N Tuberculosis (TB)

Please discuss any serious medical problems you've experienced:

_____

_____

Is there anything you would like to discuss with the doctor in private? ❑ Yes ❑ No

I understand that I am responsible (If 18 yrs or older) for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance or my parent's insurance does not cover.

_____

Patient Signature Date

_____

Parent /Guardian Signature(if necessary) Date

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

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES. I have received a copy of this office's notice of Privacy Practices. (You may refuse to sigh this acknowledgement.) I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and 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 services I may need. I also authorize Dr.'s team to leave messages about appointments on my voice mail or answering machine, and agree to receive e-mail reminders and text messages about appointments.

_____

Signature of Patient and/or Parent/Guardian Date

The Patient or Parent/Guardian is responsible for payment at time of service unless prior arrangements have been approved.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: _____/_____/_____

Doctor's Comments:

_____

_____

_____