Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Confidential Responsible Party Information

Name _____ (Last / First / Middle) Marital Status _____

Residence _____ (Street / City / State / Zip)

Mailing Address _____ (Street / City / State / Zip)

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs.) _____ (Street / City / State / Zip)

Email Address _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ (Last / First / Middle) Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Confidential Patient Information

Patient's Name _____ (Last / First / Middle) Sex: ☐ Male ☐ Female

Address _____ (Street / City / State / Zip)

Home Phone _____ Birthdate _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Insurance Information

Policy Holder's Name _____ Soc. Sec. # _____

Insuranc Company _____ Group Number _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Do you have dual coverage? ☐ Y ☐ N If yes:

Policy Holder's Name _____ Soc. Sec. # _____

Insuranc Company _____ Group Number _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

Updates (date & initials) _____

(OVER)

Dental History

Why are you interested in orthodontic treatment? _____
General Dentist _____ Date of last dental care _____
Have you ever been evaluated for othodontic treatment? ❒ Y ❒ N
Do you now or have you ever experienced pain or discomfort in your jaw joint? ❒ Y ❒ N
Have you ever experienced a mouth or chin injury? ❒ Y ❒ N
Do you have speech problems?_____
Do you usually breathe through your mouth while awake? ❒ Y ❒ N Or asleep? ❒ Y ❒ N
Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❒ Y ❒ N
Current or past habits affecting the mouth or teeth: ❒ Thumb sucking ❒ Nail biting ❒ Other _____
Other information about your dental health or previous treatment: _____

Medical History

Physician's name_____ Phone_____
Date of last visit _____ Have you ever had any serious illnesses or operations? ❒ Y ❒ N
If yes, describe _____
Are you currently under a physician's care? ❒ Y ❒ N If yes, describe _____
Have you ever had a blood transfusion? ❒ Y ❒ N If yes, give approximate dates _____
Women: Are you pregnant? ❒ Y ❒ N Nursing? ❒ Y ❒ N Taking birth control pills? ❒ Y ❒ N
Check (✔) yes or no to the following:

❒ Y ❒ N AIDS/HIV Positive
❒ Y ❒ N Anaphylaxis
❒ Y ❒ N Anemia
❒ Y ❒ N Arthritis, 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 Cough up blood
❒ 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 or 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 or loss
❒ Y ❒ N Radiation treatment
❒ Y ❒ N Respiratory treatment
❒ Y ❒ N Respiratory disease
❒ Y ❒ N Rheumatic/Scarlet fever
❒ Y ❒ N Shingles
❒ Y ❒ N Shortness of breath
❒ Y ❒ N Sinus problems
❒ Y ❒ N Skin rash
❒ Y ❒ N Spina Bifida
❒ Y ❒ N Stroke
❒ Y ❒ N Surgical implant
❒ Y ❒ N Swelling of feet or ankles
❒ Y ❒ N Thyroid disease or malfunction
❒ Y ❒ N Tobacco habit
❒ Y ❒ N Tonsillitis
❒ Y ❒ N Tuberculosis
❒ Y ❒ N Ulcer/Colitis
❒ Y ❒ N Venereal disease

List medications you are taking, if any:

_____
_____

List drug allergies, if any:

_____
_____

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 orthodontist to help determine appropriate and healthful orthodontic treatment. If there is any change in my medical status, I will inform the orthodontist.
I authorize the insurance company indicated on this form to pay to the orthodontist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
I authorize the orthdontist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date_____

Payment is due in full at time of treatment, unless prior arrangements have been approved.

*You may either print a copy of this form and bring it with you to your first visit or submit the form to send us an electronic version. Thank you.

Print Form Submit Form

Note: Please print first, once you submit you can not go back and print