

## 1. ABOUT YOU

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First M. Ini.

I prefer to be called: \_\_\_\_\_  Male  Female

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

SS#: \_\_\_\_\_

Home Address: \_\_\_\_\_

City State Zip

Single  Married  Widowed  Divorced  Separated

Hm#: \_\_\_\_\_ Cell# \_\_\_\_\_

Wk#: \_\_\_\_\_ Ext: \_\_\_\_\_

DL#: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

How long there? \_\_\_\_\_ Occupation: \_\_\_\_\_

Where & when are best times to reach you? \_\_\_\_\_

Whom may we Thank for referring you? \_\_\_\_\_

Other family members seen by us? \_\_\_\_\_

General Dentist: \_\_\_\_\_

Last Visit Date: \_\_\_\_\_

Any Treatment Rendered? \_\_\_\_\_

## 2. SPOUSE INFORMATION

His/Her Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Wk#: ( ) \_\_\_\_\_ Ext. \_\_\_\_\_

SS#: \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Person Responsible for Account: \_\_\_\_\_

Wk#: ( ) \_\_\_\_\_ Ext. \_\_\_\_\_ Hm#: ( ) \_\_\_\_\_

Billing Address: \_\_\_\_\_

Relation: \_\_\_\_\_ SS#: \_\_\_\_\_

Employer: \_\_\_\_\_

DL# \_\_\_\_\_

## 3. ORTHODONTIC INSURANCE

Orthodontic Coverage?  Yes  No

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone#: ( ) \_\_\_\_\_

Group# (Plan, local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Insured's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Insured's SS#: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

**In the event of an emergency, is there someone  
who lives near you that we should contact?**

His/Her Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Wk#: \_\_\_\_\_ Hm#: \_\_\_\_\_

## 4. MEDICAL HISTORY

Do you have a personal physician?  Yes  No

Physician's Name: \_\_\_\_\_

Phone #: ( ) \_\_\_\_\_

**Your Current physical health is:**

Good  Fair  Poor

Are you currently under the care of a physician?

Yes  No

Please explain: \_\_\_\_\_

Are you taking any 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

#### 4. MEDICAL HISTORY *continued*

Have you ever had any of the following diseases or medical problems?

- |                                      |                                  |
|--------------------------------------|----------------------------------|
| Y N Anemia/Radiation Treatment       | Y N Heart Surgery/Pacemaker      |
| Y N Artificial Bones/Joints          | Y N Hemophilia/Abnormal Bleeding |
| Y N Artificial Valves                | Y N Hepatitis                    |
| Y N Asthma Arthritis                 | Y N High/Low Blood Pressure      |
| Y N Blood Transfusion                | Y N HIV +/-AIDS                  |
| Y N Cancer/Chemotherapy              | Y N Hospitalized for Any Reason  |
| Y N Congenital Heart Defect          | Y N Kidney Problems              |
| Y N Diabetes/Tuberculosis            | Y N Mitral Valve Prolapse        |
| Y N Difficulty Breathing             | Y N Psychiatric Problems         |
| Y N Drug/Alcohol Abuse               | Y N Rheumatic/Scarlet Fever      |
| Y N Emphysema/Glaucoma               | Y N Severe/Frequent Headaches    |
| Y N Epilepsy/Seizure/Fainting Spells | Y N Shingles                     |
| Y N Fever Blisters/Herpes            | Y N Sinus Problems               |
| Y N Heart Attach/Stroke              | Y N Ulcers/Colitis               |
| Y N Heart Murmur                     | Y N Venereal Disease             |

Please list any serious medical condition(s) that you have ever had: \_\_\_\_\_

Are you allergic to any of the following?

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

Thank you for filling out this form completely

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services

Signature \_\_\_\_\_

Date \_\_\_\_\_

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

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

I verbally retrieved the medical / dental information above with the patient named herein.

Doctor's Comments \_\_\_\_\_

Initials: \_\_\_\_\_ Date: \_\_\_\_\_

#### 5. DENTAL HISTORY

What are the main concerns that you would like orthodontics to accomplish?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you ever been evaluated for orthodontic treatment?

Yes  No

Have you ever had a serious/difficult problem associated with any previous dental work?

Yes  No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ / TMD)?  Yes  No

Your current dental health is:

Good  Fair  Poor

Do you like your smile?  Yes  No

Do your gums bleed?  Yes  No

Have you ever had an injury to your: Mouth Teeth Chin

Do you have any speech problems?

\_\_\_\_\_

Do you generally breathe through your mouth?

Y N Awake? Y N Asleep?

Do you have any missing or extra permanent teeth?

Yes  No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information 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 any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature \_\_\_\_\_ Date \_\_\_\_\_