



Welcome



Patients Name _____ Social Security Number _____ Sex _____

Address _____ City _____ ZIP _____

Home Phone _____ Cell Phone _____ Carrier _____ Age _____ Birth date _____

Email _____ Dentist _____ Referred by _____

Do you know a patient currently in our practice? If so whom? _____

Who noticed orthodontic problems? Patient Dentist Other _____

Describe the orthodontic problem in your own words _____

What concerns you most about orthodontic treatment?

appearance in appliance cost length of time discomfort results other _____

Occupation _____

Employer _____ Address _____ WK Phone _____

FAMILY AND ACCOUNT INFORMATION

Spouse's Name _____ Employer _____ WK Phone _____

Person responsible for account _____

If other than self or spouse:

Name _____ Occupation _____

Address _____ City _____ Phone _____

AGREEMENT: The above information is for the purpose of obtaining credit and is warranted to be true. I authorize creditor or his agent to make a credit investigation, including employment verification.

Name of insured (Employee) _____ Date of Birth _____ Employer _____

Name of insurance company _____ Group # or SS# _____

Name of insured (Employee) _____ Date of Birth _____ Employer _____

Name of insurance company _____ Group # or SS# _____

FINANCIAL AND INSURANCE INFORMATION

I understand that I am financially responsible for any charges (including collection fees); and that I am responsible for, knowledge of my insurance program and its limitations. This office is not responsible for knowing my insurance benefits and limitations. I understand that I may request a copy of this form. I have read this authorization and understand its contents.

Signature _____ Date _____

Responsible Person for Payment

We love to make people smile!

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your orthodontic care. All information will be kept completely confidential.

Medical History

Physician's Name: _____ Address _____ Phone _____

Have you experienced any health problems?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Explain
Any major change in your health recently?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Explain
Are you currently under physician's care?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Explain
Are you currently taking medications?	<input type="checkbox"/> No <input type="checkbox"/> Yes	List:
Are you allergic to any medication?	<input type="checkbox"/> No <input type="checkbox"/> Yes	List:
Have you received a blood transfusion?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Reason:
Have your tonsils or adenoids been removed?	<input type="checkbox"/> No <input type="checkbox"/> Yes	When:
Have you been in a risk group for AIDS?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Explain

Please check if you have any of the following conditions?

- | | | |
|---|---|---|
| Heart Murmur _____ <input type="checkbox"/> No <input type="checkbox"/> Yes | Hepatitis _____ <input type="checkbox"/> No <input type="checkbox"/> Yes | Emotional Problems _____ <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Heart Surgery _____ <input type="checkbox"/> No <input type="checkbox"/> Yes | Diabetes _____ <input type="checkbox"/> No <input type="checkbox"/> Yes | Frequent Headaches _____ <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Rheumatic Fever _____ <input type="checkbox"/> No <input type="checkbox"/> Yes | Kidney Disease _____ <input type="checkbox"/> No <input type="checkbox"/> Yes | Nervous/Anxious _____ <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Endocrine Disorders _____ <input type="checkbox"/> No <input type="checkbox"/> Yes | Liver Disease _____ <input type="checkbox"/> No <input type="checkbox"/> Yes | Cancer _____ <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Anemia _____ <input type="checkbox"/> No <input type="checkbox"/> Yes | Tuberculosis _____ <input type="checkbox"/> No <input type="checkbox"/> Yes | Bone Disorder _____ <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Prolonged Bleeding _____ <input type="checkbox"/> No <input type="checkbox"/> Yes | Bronchitis _____ <input type="checkbox"/> No <input type="checkbox"/> Yes | Growth Disorder _____ <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Blood Disease _____ <input type="checkbox"/> No <input type="checkbox"/> Yes | Asthma _____ <input type="checkbox"/> No <input type="checkbox"/> Yes | Mouth Breather _____ <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Developmental Disorder _____ <input type="checkbox"/> No <input type="checkbox"/> Yes | Epilepsy _____ <input type="checkbox"/> No <input type="checkbox"/> Yes | Herpes (Fever Blister) _____ <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Hives/Rash _____ <input type="checkbox"/> No <input type="checkbox"/> Yes | Fainting _____ <input type="checkbox"/> No <input type="checkbox"/> Yes | Tonsillitis _____ <input type="checkbox"/> No <input type="checkbox"/> Yes |

Are there any other conditions or problems that you think we should know about? _____

Comments _____

Dental History

Dentist Name: _____ Address _____ Phone _____

Dentist Specialist Name: _____ Address _____ Phone _____

Frequency of dental checkups: Twice a year Once a Year Only if a problem exists Never Date of last Visit _____

Is there any unfinished care to be completed with your dentist?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Explain:
Are you anxious about dental treatment?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Explain:
Have you had an unpleasant experience in a dental office?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Explain:
Have you had any facial or dental injuries?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Explain:
Do you play any musical instrument?	<input type="checkbox"/> No <input type="checkbox"/> Yes	What instrument?
Have you consulted an orthodontist previously?	<input type="checkbox"/> No <input type="checkbox"/> Yes	With whom?
Have teeth (either baby or permanent) been removed?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Have you had any previous orthodontic treatment?	<input type="checkbox"/> No <input type="checkbox"/> Yes	With whom?
Are you satisfied with prior treatment?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Explain:
Have you noticed any changes in your bite or dental alignment recently?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Explain:

What are the chief concerns you have related to the position of your teeth or bite?

- Aesthetic Cleaning Comfort Ability to chew Stability

Please elaborate: _____

What concerns has your dentist(s) expressed concerning your bite or dental alignment:

- Wear or fractures of teeth Difficulty with cleaning related to alignment of teeth
 Bone or gum tissue loss Jaw joint or muscle tightness or discomfort
 Alignment of teeth prior to restorative dental work (crowns, bridges, etc.)

Other _____

Please check if there is a history of:

- Clenching teeth Muscular soreness around head and neck Jaw joint soreness Jaw joint popping
 Grinding teeth Headaches (more than normal) Jaw joint clicking Ringing in the ears
 Speech problems (If so, which sounds _____) Mouth breathing: Awake ___ Asleep ___

Is there any other information that may be helpful? _____

Patient's Signature _____ Date _____ Reviewed by: _____