



A Smile is for life

Patient Information

Date: _____

Name: _____
 First MI Last

Birth Date: ____/____/____ Age: _____

Home Address: _____

 City State Zip

Home Phone# _____

Parent Cell Phone# _____

Parent Email: _____

Other family members treated in our office: _____

Who may we THANK for referring you? _____

Dental Insurance

Policy Holder Name: _____

Relationship to Patient: _____

Employer: _____

Birth Date: ____/____/____

SS#: _____

ID#: _____

Group#: _____

Insurance Company: _____

Phone#: _____

Address: _____

Do you have secondary coverage? YES NO

If so please list: _____

Our office will assist in filling your insurance information if you can provide proper information. We will not accept responsibility for collecting from your insurance or for negotiating a settlement for disputed claims. Any parties noted on this form will be allowed access to your protected health information unless excluded by written request.

Responsible Party's Information

Name: _____
 If other than patient, please complete below:

Relationship to patient: _____

Billing Address: (if different) _____

 City State Zip

Home phone# : _____

Cell#: _____

Occupation: _____

Employer: _____

Work phone#: _____

Years employed there: _____

Emergency Contact

Name: _____

Relationship: _____

Phone# _____

Dental History

What concerns you most about your teeth?

Do you have any present dental problems? _____
Do you have any periodontal problems? _____
Have you ever had any pain or tenderness in the jaw joint? _____
Have you had previous orthodontic treatment? _____
Have you been under another dental specialist's care? _____
Have there been any injuries to face, mouth or teeth? _____
Do you have any previous or present tongue, thumb or finger habits?

If you answered yes to any of the above, please explain:

Do the following apply to you?

Tooth Sensitivity	_____ Yes	_____ No
Pain or ringing in ears	_____ Yes	_____ No
Mouth breathing	_____ Yes	_____ No
Grinding or clenching	_____ Yes	_____ No

Dentist Information

Dentist Name: _____ Town: _____

Phone#: _____ Date of last visit: _____

Physician Information

Physician Name: _____

Phone# _____ Last visit: _____

Are you currently under the care of a physician? YES/NO
Explain: _____

Allergies

Yes No Latex Yes No Nickel

Please list any other allergies: _____

Medical History

Yes	No	AIDS/HIV+	Yes	No	Hepatitis
Yes	No	Abnormal bleeding	Yes	No	Kidney problem
Yes	No	Asthma	Yes	No	Liver problem
Yes	No	Cancer	Yes	No	Sinus Trouble
Yes	No	Cardiac Problems	Yes	No	Thyroid problems
Yes	No	Diabetes	Yes	No	Epilepsy
Yes	No	Drug addiction	Yes	No	Venereal Disease
Yes	No	Eating disorder	Yes	No	Tuberculosis
Yes	No	Tonsil/Adenoid Condition			
Yes	No	Hearing Impairment			
Yes	No	Handicap/Disability			
Yes	No	Mental Health issues			
Yes	No	Surgical procedure			

Please explain any serious medical problems you have had:

Please list any medications you are currently taking and the correlating diagnosis:

Women:

Are you pregnant? _____

Due date: _____

Premedication

Yes	No	Heart Murmur
Yes	No	History of Rheumatic Fever
Yes	No	Has been instructed to take any medication prior to dental treatment.

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

Legal Statement

I understand the information that I have given is correct to the best of my knowledge and that it will be handled in accordance with the office privacy policy. If there are any changes during the duration of treatment, I will so inform this practice. I will not hold my orthodontist or any staff member responsible for any errors or omissions that I have made in the completion of this form.

Signature: _____ Date: _____

I authorize the orthodontic staff to perform any necessary dental services that I may need, with my informed consent. I understand that I am responsible for all costs of orthodontic treatment. I authorize release of any information needed to process insurance claims and hereby authorize payment of the orthodontic benefits otherwise payable to me directly to the provider.

Signature: _____ Date: _____