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?

____

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: __________________

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.

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

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: ___________

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:______________________________________

Premedication

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

Allergies

Yes No Latex Yes No Nickel

Please list any other allergies: ______________________________

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:** __________________