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. In the case of adult patients, you may omit answers for any fields of information that are specific to a child. We look forward to working with you!

Patient Information:

Patient Name ______________________________ __________________________ _______________________

Last Name First Name Nickname

Address____

City____________________ State________________ Zip__________ Phone#__________________________

Sex □ M □ F Age__________ Birthdate____________________ School____________________________

Grade_____________________ Hobbies? Sports?____

Whom may we thank for referring you?____

Dental History:

General Dentist______________________ Phone #__________________ Date of last visit_______________

Why are you interested in orthodontic treatment?____

How often do you brush?__________________________________ Floss?______________________________

Have you ever been evaluated for orthodontic treatment? □ Y □ N

Have you ever experienced a mouth or chin injury? □ Y □ N

Do you have any habits/problems affecting the mouth or teeth?_____________________________________

If you play a musical instrument, which one(s) do you play?_______________________________________

Do you usually breathe through your mouth while awake? □ Y □ N or asleep? □ Y □ N

Your habits affecting the mouth or teeth: □ thumb sucking □ nail biting □ other_________________________

Have you ever experienced an adverse reaction during a medical or dental procedure? □ Y □ N

Other information about your dental health or previous treatment_____________________________________

Medical History:

Physician______________________________ Phone #_________________ Date of last visit________________

Are you currently under physician care? □ Y □ N If yes, describe______________________________________

Have you had any serious illnesses or operations? □ Y □ N If yes, describe___________________________

Have you ever had a blood transfusion? □ Y □ N If yes, when_______________________________________

Have your adenoids or tonsils been removed? □ Y □ N If yes, when__________________________________

Mark if you have had any of the following:

□ AIDS/HIV Positive	□ Fainting	□ Kidney disease	□ Tonsillitis
□ Anemia	□ Food Allergies	□ Liver disease	□ Tuberculosis
□ Asthma	□ Headaches	□ Respiratory disease	□ Material allergies
□ Blood disease	□ Hearing impairment	□ Rheumatic/Scarlet fever	(latex, metal, wool, chemicals)
□ Cancer	□ Hemophilia/Abnormal bleeding	□ Sinus problems	□ Other____________
□ Convulsions/Epilepsy	□ Heart problems (describe)	□ Skin rash	____________________
□ Cough, persistent	________________________	□ Thyroid condition	____________________
□ Diabetes			

List any medications you are currently taking:

____

____

____

List any drug allergies:

____

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____

Please complete both sides.

Responsible Party Information

In the case of a child, please fill out both mom and dad's information and if anyone else is responsible. Please also indicate whether the responsible parties carry insurance or not. All information is required. Thank you!

Name____ Relationship________________________________
Birthdate______________________________________ Social Security #________________________________
Address________________________________ City_________________ State____________ Zip_____________
Home Phone # ________________Cell Phone # ___________________ Email____________________________
Employer____ Employer Phone #___________________________
Dental Insurance Company___________________________ Phone #__________________________________
Dental Insurance Address____
Subscriber #____Group #__________________________________

Name____ Relationship________________________________
Birthdate______________________________________ Social Security #________________________________
Address________________________________ City_________________ State____________ Zip_____________
Home Phone # ________________Cell Phone # ___________________ Email____________________________
Employer____ Employer Phone #___________________________
Dental Insurance Company___________________________ Phone #__________________________________
Dental Insurance Address____
Subscriber #____Group #__________________________________

Name____ Relationship________________________________
Birthdate______________________________________ Social Security #________________________________
Address________________________________ City_________________ State____________ Zip_____________
Home Phone # ________________Cell Phone # ___________________ Email____________________________
Employer____ Employer Phone #___________________________
Dental Insurance Company___________________________ Phone #__________________________________
Dental Insurance Address____
Subscriber #____Group #__________________________________

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 (or my child's medical status, if filling out on behalf of a child), 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 orthodontist 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.

Name (printed) – Use parent or guardian name, if filling out for minor___________________________________
Signature____ Date___________________________

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