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Board-Certified Specialist in Orthodontics
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WELCOME TO OUR OFFICE

So that we might become better acquainted, please complete the following:

ADULT PATIENT INFORMATION:

Patient's Name _____ Preferred Name _____ Sex _____

Birthdate _____ Age _____ Email _____

Whom may we thank for referring you to our office? _____

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

Who noticed orthodontic problem? ❑ Patient ❑ Dentist ❑ Other _____

Describe the orthodontic problem in your own words _____

What concerns you most about orthodontic treatment?

❑ Appearance in appliances ❑ Cost ❑ Length of time ❑ Discomfort ❑ Results ❑ Other _____

FAMILY AND ACCOUNT INFORMATION

	PATIENT	SPOUSE
Name:		
Address:		
Phone:		
Social Security Number:		
Employer's Name:		
Business Address:		
Business Phone:		
Occupation:		
How long with this Employer:		
Person Responsible for Account:		

If other than patient or spouse:

Name _____ Address _____ Phone _____

In case of emergency, please provide name, address and phone number of your nearest relative

_____

NAME ADDRESS PHONE

INSURANCE INFORMATION

For your convenience, we will gladly assist you in submitting insurance claims pertaining to any charge for care in our office. If you wish assistance, we ask that you provide us with claim forms from your insurance carrier on your first visit. Otherwise we will assume you are submitting all claims to your insurance carrier.

Name of Insured (Employee) _____ Date of Birth _____

Name of Insurance Company _____ Group # _____

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(over)

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

MEDICAL HISTORY

Physician's Name: _____ Address _____ Phone _____

Have you experienced any health problems? ❑ No ❑ Yes Explain: _____
Any major change in your health recently? ❑ No ❑ Yes Explain: _____
Are you currently under a physician's care? ❑ No ❑ Yes Explain: _____
Are you currently taking medications? ❑ No ❑ Yes List: _____
Are you allergic to any medications? ❑ No ❑ Yes List: _____
Have you received a blood transfusion? ❑ No ❑ Yes Reason: _____
Have your tonsils or adenoids been removed? ❑ No ❑ Yes When: _____
Have you been in a risk group for AIDS? ❑ No ❑ Yes Explain: _____
Are you currently taking bisphosphonates? ❑ No ❑ Yes Explain: _____

Please check if you have had any of the following conditions:

Heart Murmur	❑ No	❑ Yes	Hepatitis	❑ No	❑ Yes	Emotional Problems	❑ No	❑ Yes
Heart Surgery	❑ No	❑ Yes	Diabetes	❑ No	❑ Yes	Frequent Headaches	❑ No	❑ Yes
Rheumatic Fever	❑ No	❑ Yes	Kidney Disease	❑ No	❑ Yes	Nervous/Anxious	❑ No	❑ Yes
Endocrine Disorders	❑ No	❑ Yes	Liver Disease	❑ No	❑ Yes	Cancer	❑ No	❑ Yes
Prolonged Bleeding	❑ No	❑ Yes	Tuberculosis	❑ No	❑ Yes	Bone Disorders	❑ No	❑ Yes
Anemia	❑ No	❑ Yes	Bronchitis	❑ No	❑ Yes	Growth Disorders	❑ No	❑ Yes
Blood Disease	❑ No	❑ Yes	Asthma	❑ No	❑ Yes	Mouth Breather	❑ No	❑ Yes
Developmental Disorder	❑ No	❑ Yes	Epilepsy	❑ No	❑ Yes	Herpes (Fever Blisters)	❑ No	❑ Yes
Hives/Rash	❑ No	❑ Yes	Fainting	❑ No	❑ Yes	Tonsillitis	❑ No	❑ Yes

Is there any other condition or problem that you think we should know about? _____

_____

Comments _____

_____

DENTAL HISTORY

Dentist's Name _____ Address _____ Phone _____
Dental Specialist's 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? ❑ No ❑ Yes Explain: _____
Are you frightened about dental treatment? ❑ No ❑ Yes Explain: _____
Have you had an unpleasant experience in a dental office? ❑ No ❑ Yes Explain: _____
Have you had any face or dental injuries? ❑ No ❑ Yes Explain: _____
Do you play a musical instrument? ❑ No ❑ Yes What instrument? _____
Have you consulted an orthodontist previously? ❑ No ❑ Yes With whom? _____
Have teeth (either primary or permanent) been removed? ❑ No ❑ Yes
Have you had any previous orthodontic treatment? ❑ No ❑ Yes With whom? _____
Are you satisfied with prior treatment? ❑ No ❑ Yes Explain: _____
Have you noticed any changes in your bite or dental alignment recently? ❑ No ❑ 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 & neck ❑ Jaw joint soreness ❑ Jaw point popping
❑ Grinding teeth ❑ Headaches (more than normal) ❑ Jaw point clicking ❑ Ringing in the ears
❑ Speech problems (if so, which sounds _____) ❑ Mouthbreathing: Awake___ Asleep___
❑ Has you jaw ever locked ❑ open ❑ or shut When? _____

Is there any other information which may be helpful? _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE, I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR UPDATING ANY CHANGES OR ADDITIONS TO THIS INFORMATION IN THE FUTURE. I CONSENT TO A CREDIT REPORT.

_____ Reviewed by: _____
Patient's Signature Date