WELCOME TO OUR OFFICE

So that we might become better acquainted, please complete this form.

PATIENT INFORMATION

Patient's Name _____ Prefer to be called _____ Sex_____

Mailing Address_____ City _____ Zip_____

Cell Phone_____ Age_____ Birth date_____

Email _____

Patient's Dentist _____ Phone Number_____

Referred by _____Do you know a patient currently in our practice? Whom _____

What concerns you most about the thought of orthodontic treatment?

[ ] appearance in appliances [ ] cost [ ] length of time [ ] discomfort [ ] results [ ] other _____

Occupation _____ Employer _____

Address _____ Work Phone _____

Person responsible for account _____

Social Security # (Responsible Party) _____

FAMILY AND ACCOUNT INFORMATION

[ ] Mother [ ] Father [ ] Spouse [ ] Other: _____

Name _____ Employer _____

Address _____ City _____ Zip _____

Cell Phone_____ Work Phone_____ No. of years employed _____

[ ] Mother [ ] Father [ ] Spouse [ ] Other: _____

Name _____ Employer _____

Address _____ City _____ Zip _____

Cell Phone_____ Work Phone_____ No. of years employed _____

INSURANCE INFORMATION

Primary Insurance

Name of insured (Employee) _____ DOB_____ ID#_____

Insurance Co._____Group # _____ Social Security #_____

Employer_____ Ins. Phone # _____

Secondary Insurance

Name of insured (Employee) _____ DOB_____ ID#_____

Insurance Co._____Group # _____ Social Security #_____

Employer_____ Ins. Phone # _____

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

MEDICAL HISTORY

Physician's Name_____Phone_____

Have you experienced any health problems?	[ ] No [ ] Yes	Explain:_____
Any major change in your health recently?	[ ] No [ ] Yes	Explain:_____
Are you currently under physician's care?	[ ] No [ ] Yes	Explain:_____
Are you currently taking medications?	[ ] No [ ] Yes	List:_____
Are you allergic to any medications?	[ ] No [ ] Yes	List:_____
Are you allergic to latex or metals?	[ ] 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:_____

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	AIDS	[ ] 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_____ **City:**_____ **State**____ **Zip**_____ **Phone**_____

Frequency of dental checkups: Twice a year [ ] Once a year [ ] Only if a problem exist [ ] 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 any musical instruments?	[ ] No [ ] Yes	What instrument?_____
Have you consulted an orthodontist previously?	[ ] No [ ] Yes	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 concern 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 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?_____

I the undersigned have given the above dental and medical information, have reviewed it and find it accurate. If there are any changes to this record, I will inform this practice.

_____ _____ _____

Patient's signature **Date** **Reviewed by**

FOR DOCTOR'S USE ONLY. PREMEDICATE FOR BANDING / DEBANDING [ ] YES [ ] NO