



TELL US ABOUT YOURSELF

Today's Date: _____

Preferred Name: _____

Name: _____
Last First MI

E-Mail Address: _____

SS# _____ Birthdate ____/____/____

Age: _____ Male Female

Hobbies/Sports: _____

Home#: (____) _____

Cell#: (____) _____

Address: _____

City State Zip

PRIMARY ORTHODONTIC INSURANCE

Orthodontic Coverage: Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

City State Zip

Insurance Co. Phone #: (____) _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____

SS#: _____

Policy Owner's Employer: _____

Employer's Address: _____

City State Zip

Group # (Plan, Local or Policy #): _____

Has any of your orthodontic maximum been used for Orthodontic treatment? Yes No

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relation: _____

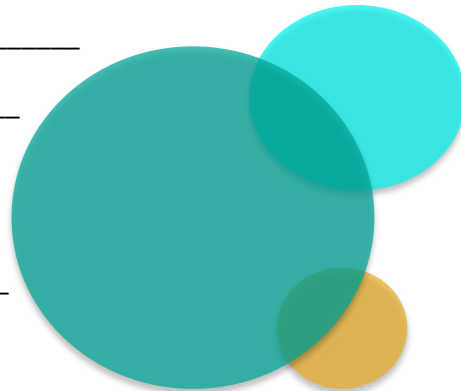
Billing Address: _____

City State Zip

Hm#: (____) _____ Cell#: (____) _____

Wk#: (____) _____ Ext: _____

DL#: _____ SS#: _____



What are the concerns that you would like orthodontics

to accomplish? _____

Have you Ever taken Phen-Fen? Yes No
(also known as Redux or Pondimin)

Have you ever been evaluated or had orthodontic treatment before? Yes No

Have you had any injuries to the face, mouth, teeth or chin? Yes No

List any musical instrument played: _____

Have adenoids or tonsils been removed? Yes No

Have you been informed of any missing or extra permanent teeth? Yes No

Have you had any pain/tenderness in your jaw joint (TMJ/JMD)? Yes No

Do you brush your teeth daily? Yes No

Floss your teeth daily? Yes No

Physician's Name: _____

Phone#: (____) _____ Date of last visit _____

Are you under the care of a physician? Yes No

Please describe your current physical health:

Good Fair Poor

Please list all drugs you are currently taking:

Please list all drugs/things you are allergic to:

• I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

• This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fee and may, at the discretion of one or more credit reporting services.

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

The Parent or Guardian who accompanies this child is responsible for payment. Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and ADA.

HAVE YOU HAD ANY OF THE FOLLOWING PROBLEMS?

- | | |
|------------------------------------|----------------------------|
| Y N Abnormal Bleeding | Y N Convulsions/Epilepsy |
| Y N ADD/ADHD | Y N Diabetes |
| Y N Allergies to drugs | Y N Handicaps/Disabilities |
| Y N Allergies to latex | Y N Allergies to metal |
| Y N Hearing Impairment | Y N Allergic to Plastic |
| Y N Heart Murmur | Y N Any Hospital Stays |
| Y N Hemophilia | Y N Any Operations |
| Y N Hepatitis | Y N HIV/AIDS |
| Y N Asthma | Y N Kidney/Liver Problems |
| Y N Cancer | Y N Tuberculosis (TB) |
| Y N Congenital Heart Defect | |
| Y N Artificial Bones/Joints/Valves | |
| Y N Rheumatic/Scarlet Fever | |

Please discuss any medical problems you have had:

HAVE YOU HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

- | | |
|------------------------------|------------------------|
| Y N Nursing Bottle Habits | Y N Lip Sucking/Biting |
| Y N Speech Problems | Y N Mouth Breather |
| Y N Nail Biting | Y N Tongue Thrust |
| Y N Thumb/Finger Sucking | |
| Y N Clenching/Grinding Teeth | |

NEIGHBOR OR RELATIVE NOT LIVING WITH YOU.

NAME: _____ Phone: (____) _____

Address: _____

_____ City State Zip

• I authorize the dental staff to perform any necessary dental services I may need.

If this office accepts insurance, I understand that I am Responsible for payments of services rendered and also Responsible for paying any co-payment and deductibles that my insurance does not cover.

Signature Date