WELCOME

We would like to welcome you to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. Thank you for your cooperation.

Patient Information - Adult

Patient's Name _____ Age _____ Birth Date _____
(First / Middle / Last)

Nickname (if preferred) _____ ○ Male ○ Female

Home Phone _____ Cell Phone _____ SS # _____

Home Address _____ City, State, ZIP _____
(Street)

Employer _____ Employer's Address _____

Occupation _____ How Long? _____

General Dentist _____ How did you hear about our office? _____

Have we treated another member of your family? ○ YES ○ NO If YES, Name _____
(First / Middle / Last)

What are the main concerns that you would like orthodontics to accomplish? _____

Have you visited an orthodontist before? ○ YES ○ NO If YES, for what reason? _____

Anything you would like to discuss with the doctor in private? ○ YES ○ NO

Insurance Information

Marital Status ○ Single ○ Married ○ Widowed ○ Divorced ○ Separated ○ Domestic Partner

Primary

Insurance Company Name _____ Insurance Company Phone _____

Insurance Company Address _____ Group or Plan _____

Insured's Name _____ Insured's Birthdate _____

Relationship _____ Insured's SS # _____

Insured's Employer _____ Employer's Address _____

Secondary

Insurance Company Name _____ Insurance Company Phone _____

Insurance Company Address _____ Group or Plan _____

Insured's Name _____ Insured's Birthdate _____

Relationship _____ Insured's SS # _____

Insured's Employer _____ Employer's Address _____

Dental and Medical History

Are you currently under the care of a physician? ○ YES ○ NO If YES, for what reason? _____

Physician _____ Phone # _____

History of major illness? ○ YES ○ NO If YES, please describe _____

Any sensitivities or allergies? ○ YES ○ NO If YES, please list _____

Currently taking any medications? ○ YES ○ NO If YES, please list _____ Amount/Dose _____

Have you been treated for any of the following?

☐ Arthritis	☐ Blood Disorder	☐ Diabetes	☐ Heart Condition	☐ Tuberculosis
☐ Asthma	☐ Cancer	☐ Epilepsy	☐ Nervous Disorder	☐ High Blood Pressure

Do you require antibiotics before dental treatment? ○ YES ○ NO If YES, explain _____

Have there been injuries to your face, mouth or chin? ○ YES ○ NO

Have you ever had pain/tenderness in your jaw joint (TMJ/TMD) ○ YES ○ NO

Do/Did you have any of the following habits?

☐ Grinding Teeth	☐ Finger/Thumb Sucking	☐ Tongue Thrusting
☐ Chronic Mouth Breathing	☐ Speech Problems	☐ Chewing/Eating Problems

Signature

I understand that the information that I have provided 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.

I hereby authorize release of any information related to insurance claim. I consent to examination by the doctor and I authorize payment of any insurance benefits.

Signature _____ Date _____