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!

Patient Name_____ ❑ Male ❑ Female

Social Security #_____ Birth Date _____ Driver License # _____

Home Address_____

City _____ State_____ Zip_____

Primary Phone # _____ ❑home ❑cell Ok to leave Message? ❑Y ❑N

Secondary Phone # _____ ❑home ❑cell ❑other Ok to leave Message? ❑Y ❑N

Email Address_____

Employer's Name _____ Occupation_____

Marital Status ❑ Single ❑Married ❑ Divorced ❑ Widowed ❑ Significant Other

Spouse/Partner's Name _____

Emergency Contact Name _____

Address_____

City _____ State_____ Zip_____

Phone # _____ Relation to you _____

Person(s) OK to release appointment or medically related information to concerning you.

_____ Relation _____

Primary Insurance Company _____ Phone Number _____

Group # _____ Policy # _____

Policy Holder's Name _____ Relation _____

Policy Holder's Social Security #_____ Policy Holder's Birth Date _____

Employer _____ Work Phone #_____

Co-pay (if known) _____ Deductible (if known) _____

Secondary Insurance Company _____ Phone Number _____

Group # _____ Policy # _____

Policy Holder's Name _____ Relation _____

Policy Holder's Social Security #_____ Policy Holder's Birth Date _____

Employer _____ Work Phone #_____

Co-pay (if known) _____ Deductible (if known) _____

General Dentist _____ Last Visit _____

How did you hear about our Practice? ❑Ad ❑Internet ❑ Family or Friend ❑Physician ❑Other

Name of person referring (if applicable) _____

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

_____

Have you visited an orthodontist before? ❑Y ❑N

When? _____ Reason? _____

Have your tonsils or adenoids been removed? ❑Y ❑N

Have you ever experienced jaw joint pain/ discomfort (TMJ/TMD) ? ❑Y ❑N

Do you have any missing or extra permanent teeth? ❑Y ❑N

Have you ever had an injury to (*select all that apply*) : ❑Teeth ❑Mouth ❑Chin

Do you have speech problems? ❑Y ❑N If so, explain _____

Do your gums bleed? ❑Y ❑N Do you smoke? ❑Y ❑N Do you like your smile? ❑Y ❑N

Do you currently or have you ever had any of the following habits (*check all that apply*)?

❑Clenching/Grinding Teeth ❑Nail biting

❑Lip Sucking/Biting ❑Thumb/ Finger Sucking

❑Mouth Breathing ❑Chewing/Eating Problems

Are you currently being treated by a physician? ❑Y ❑N

Physician _____ Last Visit _____ Phone _____

Reason _____

Do you have any allergies/sensitivities to medications or latex? ❑Y ❑N If yes, please list allergies.

_____

Are you currently taking any prescription or over-the-counter medications? ❑Y ❑N

Please list, with dosage. _____

Are you pregnant or nursing? ❑Y ❑N ❑N/A

- I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my medical status.
- I hereby authorize the release of any information pertaining to my medical treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payment of any benefits to the office. I understand that I am responsible for any amount not covered by insurance.
- I understand that where appropriate, credit bureau reports may be obtained.

_____ _____

Patient Signature and/or Responsible Party (i.e. POA or Guarantor) Date