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 and bring to your appointment. Thank you for your cooperation.

Patient Information - Adult

Patient's Name______________________________ Age________Birth Date_______________
First Middle Last

Nickname (if preferred)____________________ ❍Male ❍Female SS#_________________________

Home Address____

Mailing Address ____

How long at this address?_____________________ Email Address ______________________

Previous Address (If less than 3 yrs.) ____

Home phone_________________ Cell Phone_________________ Work Phone _______________

Employer_____________________ Occupation_____________________ # of years employed ___________

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

Spouse's Name__________________ Birth Date__________ SS#______________ Work Phone_______________

Employer_____________________ Occupation_____________________ # of years employed___________

How did you hear about our office? ____

Have we treated any other member of your family? ❍Yes ❍No If Yes, Name ______________________

Primary Insurance Information

Insurance Co. Name_________________________ Group/Plan #______________ SS#/ID# ________________

Insurance Co. Phone #________________ Insurance Company Address ______________________________

Insured's Name__________________________ Birth Date_________________ Relationship _______________

Insured's Employer____________________ Employer's Address _____________________________________

Secondary Insurance Information

Insurance Co. Name_________________________ Group/Plan #______________ SS#/ID# ________________

Insurance Co. Phone #________________Insurance Company Address ______________________________

Insured's Name__________________________ Birth Date_________________ Relationship _______________

Insured's Employer____________________ Employer's Address _____________________________________

Medical History

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

Physician____ Phone # ______________________________

❍YES ❍NO History of any major illness? If YES, please describe ______________________________

❍YES ❍NO Currently taking any medications? If YES, please list ______________________________

❍YES ❍NO Allergic to any medications? If YES, please list ______________________________

❍YES ❍NO Are you LATEX sensitive?

❍YES ❍NO Are you currently taking or have been given oral or intravenous Biophosphates (i.e. Fosamax, Actonel, Boniva)?

❍YES ❍NO If female, are you pregnant?

Have you been treated for any of the following?

❍Allergies ❍Arthritis ❍ Asthma ❍Blood/Bleeding Disorder ❍High Blood Pressure

❍Cancer ❍Diabetes ❍Epilepsy ❍Tuberculosis ❍Heart Conditions

❍Hepatitis ❍HIV/AIDS ❍Headaches ❍ Nervous Disorder ❍ Rheumatic Fever

Are there any medical conditions that we have not discussed that we should be aware of?________________________

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Dental History

Dentist____ Date of Last Visit ______________________

❍YES ❍NO Do you require antibiotics before dental treatment? If YES, explain ______________________

❍YES ❍NO Have there been injuries to your face, mouth or chin? If YES, explain ______________________

❍YES ❍NO Have any teeth (including baby teeth) been extracted by a dentist?

❍YES ❍NO Have tonsils and/or adenoids been removed?

❍YES ❍NO Have you ever had pain/tenderness/clicking/popping in your jaw joint (TMJ/TMD)?

❍YES ❍NO Have you had previous orthodontic treatment? IF YES, for what reason ______________________

Do/Did you have any of the following habits?

❍Grinding/Clenching Teeth ❍Finger/Thumb Sucking ❍Tongue Thrusting ❍Lip Sucking/Biting

❍Chronic Mouth Breathing ❍Speech/Tongue Problems ❍Chewing/Eating Problems ❍Nail Biting

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

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Signature

I understand that the information 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 medical status.

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

I understand that where appropriate, credit bureau reports may be obtained.

Signature____ Date ______________________________

Office Use Only

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

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Patient's/Parents' Signature Date