

PATIENT INFORMATION

PATIENT NAME (FIRST, MI, LAST) <input type="checkbox"/> MR <input type="checkbox"/> MRS <input type="checkbox"/> MS <input type="checkbox"/> MISS <input type="checkbox"/> DR <input type="checkbox"/> REV					SEX <input type="checkbox"/> M <input type="checkbox"/> F		TODAY'S DATE / /		
MAILING ADDRESS				CITY			STATE	ZIP CODE	
DATE OF BIRTH / /		SOCIAL SECURITY #			HOME PHONE #			CELL PHONE #	
AGE	GRADE	SCHOOL		IF A MINOR, PARENT/ GUARDIAN NAME			WORK PHONE # (EXTENSION)		
PLEASE LIST YOUR ORTHODONTIC CONCERNS FOR PATIENT:				OTHER CHILDREN AND AGES: (DID THEY HAVE BRACES?)					
WHOM CAN WE THANK FOR REFERRING YOU? (PLEASE FILL OUT)				WHERE DID YOU SEE OUR NAME OR LOGO? (PLEASE FILL OUT)					
EMAIL ADDRESS (FOR APPOINTMENT REMINDERS, CORRESPONDENCE, ETC.)									

PRIMARY RESPONSIBLE PARTY INFORMATION

NAME (FIRST, MI, LAST) <input type="checkbox"/> SAME AS ABOVE <input type="checkbox"/> MR <input type="checkbox"/> MRS <input type="checkbox"/> MS <input type="checkbox"/> MISS <input type="checkbox"/> DR <input type="checkbox"/> REV					DATE OF BIRTH / /		RELATIONSHIP TO PATIENT		
BILLING ADDRESS <input type="checkbox"/> SAME AS ABOVE				CITY			STATE	ZIP CODE	
SOCIAL SECURITY # (MUST COMPLETE)			HOME PHONE #		CELL PHONE #			WORK PHONE # (EXTENSION)	
ORTHODONTIC COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW			EMPLOYER NAME (MUST COMPLETE)			GROUP ID # (MUST COMPLETE)			
DENTAL INSURANCE NAME		IN OUT	INSURANCE PHONE #	LIFETIME MAX	%	DEDUCTIBLE	PAYOUT	AGE	USED
DENTAL INSURANCE ADDRESS				CITY			STATE	ZIP CODE	

SECONDARY RESPONSIBLE PARTY INFORMATION

NAME (FIRST, MI, LAST) <input type="checkbox"/> SAME AS ABOVE <input type="checkbox"/> MR <input type="checkbox"/> MRS <input type="checkbox"/> MS <input type="checkbox"/> MISS <input type="checkbox"/> DR <input type="checkbox"/> REV					DATE OF BIRTH / /		RELATIONSHIP TO PATIENT		
BILLING ADDRESS <input type="checkbox"/> SAME AS ABOVE				CITY			STATE	ZIP CODE	
SOCIAL SECURITY # (MUST COMPLETE)			HOME PHONE #		CELL PHONE #			WORK PHONE # (EXTENSION)	
ORTHODONTIC COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW			EMPLOYER NAME (MUST COMPLETE)			GROUP ID # (MUST COMPLETE)			
DENTAL INSURANCE NAME		IN OUT	INSURANCE PHONE #	LIFETIME MAX	%	DEDUCTIBLE	PAYOUT	AGE	USED
DENTAL INSURANCE ADDRESS				CITY			STATE	ZIP CODE	

SIGNATURE MUST BE COMPLETE

I AM AWARE THAT I, NOT MY INSURANCE COMPANY, AM RESPONSIBLE FOR THIS ENTIRE ACCOUNT ALTHOUGH THE INSURANCE COMPANY MAY PAY A PORTION OF THE FEE CHARGED. I AGREE TO BE RESPONSIBLE FOR ALL CHARGES FOR DENTAL SERVICES AND MATERIALS NOT PAID BY MY DENTAL BENEFIT PLAN, UNLESS THE TREATING DENTIST/ORTHODONTIST OR DENTAL PRACTICE HAS A CONTRACTUAL AGREEMENT WITH MY PLAN PROHIBITING ALL OR A PORTION OF SUCH CHARGES. I HEREBY AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO MY ORTHODONTIST TO THE EXTENT PERMITTED UNDER APPLICABLE LAW, I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I AUTHORIZE COMMUNICATION VIA PHONE, TEXT, & EMAIL FOR APPOINTMENT REMINDERS, CORRESPONDENCE, ETC.

SIGNATURE OF EMPLOYEE/SUBSCRIBER					TODAY'S DATE / /				
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DENTAL HISTORY										
Dentist's Name:										
Dentist's Address:										
Dentist's Phone #										
X	PLEASE X IF PATIENT HAS OR HAS HAD ANY BELOW:									
	Chipped or otherwise injured teeth				Has patient ever had a prior orthodontic exam or treatment?			<input type="checkbox"/> Y	<input type="checkbox"/> N	
	History of speech problems				Orthodontist Name & Treatment:					
	Abnormal swallowing habit (tongue thrusting)				Is this a 2nd opinion? (Select Yes or No)			<input type="checkbox"/> Y	<input type="checkbox"/> N	
	Teeth sensitive to hot or cold; teeth throb or ache				X	CONCERNS:		X	CONCERNS:	
	Jaw fractures, cysts, mouth infections					Price			Insurance/Flex	
	Root canal treatment or "Dead Teeth"					Treatment Options			Treatment Necessity	
	Bleeding gums, Periodontal disease, or "Gum Problems"					Timing of Treatment			Office Location/Proximity	
	Cold sores, frequent canker sores, or "Gum Boils"					Other (please list):				
	Mouth breathing habit, snoring, or difficulty breathing									
	Tooth grinding, jaw clenching, clicking, or locking				Would the patient object to wearing braces?			<input type="checkbox"/> Y	<input type="checkbox"/> N	
	Pain or soreness in the jaw or muscles of the face				Is patient taking any form of fluoride?			<input type="checkbox"/> Y	<input type="checkbox"/> N	
	Treatment for "TMJ" problems or facial muscle pain				How often does patient brush?		Floss?			
	Difficulty encountered in chewing or jaw opening				Family history of jaw problems or surgery?					
	History of "extra" or congenitally missing teeth				Onset of puberty/menarche (Adolescent Patients Only) :					
	Removal of any permanent teeth? Baby teeth? (circle)				Female Patients Only (For X-Ray Concerns):					
	Any loose, broken, or missing restorations (fillings)							Are you pregnant?	<input type="checkbox"/> Y	<input type="checkbox"/> N
	Has patient ever had periodontal (gum) treatment?							Are you taking birth control pills?	<input type="checkbox"/> Y	<input type="checkbox"/> N
	Thumb or finger-sucking habit? Until:							Anticipating becoming pregnant?	<input type="checkbox"/> Y	<input type="checkbox"/> N
MEDICAL HISTORY										
Please list ALL current medications and supplements:										
Is patient allergic to any medications? Other allergies? List:										
List other conditions that we should be aware of to better treat the patient?										
X	PLEASE X IF PATIENT HAS OR HAS HAD ANY BELOW:				X	PLEASE X IF PATIENT HAS OR HAS HAD ANY BELOW:				
	Heart murmur- If so, do you take antibiotics? <input type="checkbox"/> Y <input type="checkbox"/> N					ADD, ADHD, OCD, ASD, ODD, Asperger's (circle)				
	Rheumatic fever, heart problem, pacemaker					Asthma, hay fever, sinus trouble, hives				
	Nickel or latex allergy? (circle)					Behavioral or mental health disorder				
	Recovering addict? How long have you been in recovery?					High or low blood pressure				
	Bone fractures or any major accidents					Fainting, seizures, epilepsy, or neurological problem				
	Tonsil or adenoid conditions? Removed? <input type="checkbox"/> Y <input type="checkbox"/> N					Drug, alcohol, or substance abuse past or present				
	Diabetes, endocrine, thyroid, or kidney problems					Problems of the immune system				
	Cancer, tumor, or radiation treatment					AIDS or HIV positive				
	Hepatitis, jaundice, or liver problem					Frequent headaches, colds, or sore throats (circle)				
	Tuberculosis, mononucleosis, polio, or pneumonia					Rheumatoid or arthritic conditions				
SIGNATURE MUST BE COMPLETE										
I HAVE READ AND UNDERSTAND THE ABOVE MEDICAL AND DENTAL QUESTIONNAIRE. I WILL NOT HOLD MY ORTHODONTIST OR ANY OTHER MEMBER OF HIS OR HER STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I HAVE MADE IN THE COMPLETION OF THIS FORM. IF THERE ARE ANY CHANGES LATER TO THE HISTORY RECORD OR MEDICAL AND DENTAL STATUS, I WILL SO INFORM THE PRACTICE.										
SIGNATURE OF PATIENT/PARENT/GUARDIAN					TODAY'S DATE / /		SIGNATURE OF DOCTOR			