PATIENT INFORMATION

PATIENT NAME (FIRST, MI, LAST) □ MR □ MRS □ MS □ MISS □ DR □ REV	SEX □ M □ 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) □ SAME AS ABOVE □ MR □ MRS □ MS □ MISS □ DR □ REV	DATE OF BIRTH / /	RELATIONSHIP TO PATIENT

BILLING ADDRESS □ SAME AS ABOVE	CITY	STATE	ZIP CODE

SOCIAL SECURITY # (MUST COMPLETE)	HOME PHONE #	CELL PHONE #	WORK PHONE # (EXTENSION)

ORTHODONTIC COVERAGE? □ YES □ NO □ 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) □ SAME AS ABOVE □ MR □ MRS □ MS □ MISS □ DR □ REV	DATE OF BIRTH / /	RELATIONSHIP TO PATIENT

BILLING ADDRESS □ SAME AS ABOVE	CITY	STATE	ZIP CODE

SOCIAL SECURITY # (MUST COMPLETE)	HOME PHONE #	CELL PHONE #	WORK PHONE # (EXTENSION)

ORTHODONTIC COVERAGE? □ YES □ NO □ 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 / /**

PATIENT INFORMATION

PATIENT NAME (FIRST, MI, LAST) □ MR □ MRS □ MS □ MISS □ DR □ REV	SEX □ M □ F	TODAY'S DATE / /

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
	History of speech problems
	Abnormal swallowing habit (tongue thrusting)
	Teeth sensitive to hot or cold; teeth throb or ache
	Jaw fractures, cysts, mouth infections
	Root canal treatment or "Dead Teeth"
	Bleeding gums, Periodontal disease, or "Gum Problems"
	Cold sores, frequent canker sores, or "Gum Boils"
	Mouth breathing habit, snoring, or difficulty breathing
	Tooth grinding, jaw clenching, clicking, or locking
	Pain or soreness in the jaw or muscles of the face
	Treatment for "TMJ" problems or facial muscle pain
	Difficulty encountered in chewing or jaw opening
	History of "extra" or congenitally missing teeth
	Removal of any permanent teeth? Baby teeth? (circle)
	Any loose, broken, or missing restorations (fillings)
	Has patient ever had periodontal (gum) treatment?
	Thumb or finger-sucking habit? Until:

		Y	N
Has patient ever had a prior orthodontic exam or treatment?			
Orthodontist Name & Treatment:			
Is this a 2nd opinion? (Select Yes or No)			
Would the patient object to wearing braces?			
Is patient taking any form of fluoride?			
Are you pregnant?			
Are you taking birth control pills?			
Anticipating becoming pregnant?			

How often does patient brush?	Floss?		
Family history of jaw problems or surgery?			
Onset of puberty/menarche (Adolescent Patients Only) :			

X	CONCERNS:	X	CONCERNS:
	Price		Insurance/Flex
	Treatment Options		Treatment Necessity
	Timing of Treatment		Office Location/Proximity
	Other (please list):		

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:	Y	N	
	Heart murmur- If so, do you take antibiotics?			
	Rheumatic fever, heart problem, pacemaker			
	Nickel or latex allergy? (circle)			
	Recovering addict? How long have you been in recovery?			
	Bone fractures or any major accidents			
	Tonsil or adenoid conditions? Removed?			
	Diabetes, endocrine, thyroid, or kidney problems			
	Cancer, tumor, or radiation treatment			
	Hepatitis, jaundice, or liver problem			
	Tuberculosis, mononucleosis, polio, or pneumonia			

X	PLEASE X IF PATIENT HAS OR HAS HAD ANY BELOW:
	ADD, ADHD, OCD, ASD, ODD, Asperger's (circle)
	Asthma, hay fever, sinus trouble, hives
	Behavioral or mental health disorder
	High or low blood pressure
	Fainting, seizures, epilepsy, or neurological problem
	Drug, alcohol, or substance abuse past or present
	Problems of the immune system
	AIDS or HIV positive
	Frequent headaches, colds, or sore throats (circle)
	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 OMISSSIONS 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