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Specialists in Orthodontics

# 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 to the office.**

Signature \_\_\_\_\_ Date \_\_\_\_\_