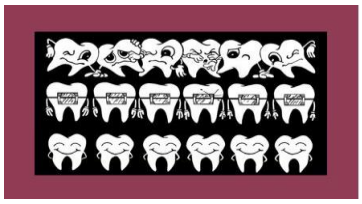

Welcome

Patients Name _____ Preferred Name _____ Sex _____

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____ Birth date _____ Age ____

Email _____ Dentist _____ Referred by _____

Do you know a patient currently in our practice? If so, whom? _____

Who noticed orthodontic problems? ☐ Patient ☐ Dentist ☐ Other _____

Describe the orthodontic problem in your own words _____

_____

What concerns you most about orthodontic treatment?
☐ Appearance ☐ Cost ☐ Length of time ☐ Discomfort ☐ Results ☐ Other _____

Occupation _____ Employer _____

FAMILY AND ACCOUNT INFORMATION

Spouse's Name _____ Employer _____

Person responsible for account _____

If other than self or spouse:

Name _____ Occupation _____

Address _____ City _____ Phone _____

DENTAL INSURANCE INFORMATION

Name of insured (Employee) _____ Date of Birth _____ Employer _____

Name of insurance _____ Group# _____ ID# or SS# _____

Name of insured (Employee) _____ Date of Birth _____ Employer _____

Name of insurance _____ Group# _____ ID# or SS# _____

FINANCIAL AND INSURANCE INFORMATION

I understand that I am financially responsible for any charges (including collection fees); and that I am responsible for knowledge of my insurance program and its limitations. This office is not responsible for knowing my insurance benefits and limitations. I understand that I may request a copy of this form. I have read this authorization and understand its contents.

Signature _____ Date _____

Responsible Person for Payment

We love to make people smile!

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your orthodontic care. All information will be kept completely confidential.

Medical History

Physician's Name:_____ Address _____ Phone _____

Have you experienced any health problems? ☐No ☐ Yes	Explain
Any major change in your health recently? ☐No ☐ Yes	Explain
Are you currently under physician's care? ☐No ☐ Yes	Explain
Are you currently taking medications? ☐No ☐ Yes	List:
Are you allergic to any medication? ☐No ☐ Yes	List:
Have you received a blood transfusion? ☐No ☐ Yes	Reason:
Have your tonsils or adenoids been removed? ☐No ☐ Yes	When:
Have you been in a risk group for AIDS? ☐No ☐ Yes	Explain

Please check if you have any of the following conditions?

Heart Murmur	☐No ☐Yes	Hepatitis	☐No ☐Yes	Emotional Problems	☐No ☐Yes
Heart Surgery	☐No ☐Yes	Diabetes	☐No ☐Yes	Frequent Headaches	☐No ☐Yes
Rheumatic Fever	☐No ☐Yes	Kidney Disease	☐No ☐Yes	Nervous/Anxious	☐No ☐Yes
Endocrine Disorders	☐No ☐Yes	Liver Disease	☐No ☐Yes	Cancer	☐No ☐Yes
Anemia	☐No ☐Yes	Tuberculosis	☐No ☐Yes	Bone Disorder	☐No ☐Yes
Prolonged Bleeding	☐No ☐Yes	Bronchitis	☐No ☐Yes	Growth Disorder	☐No ☐Yes
Blood Disease	☐No ☐Yes	Asthma	☐No ☐Yes	Mouth Breather	☐No ☐Yes
Developmental Disorder	☐No ☐ Yes	Epilepsy	☐No ☐Yes	Herpes (Fever Blister)	☐No ☐Yes
Hives/Rash	☐No ☐ Yes	Fainting	☐No ☐Yes	Tonsillitis	☐No ☐Yes

Are there any other conditions or problems that you think we should know about?_____

Comments_____

_____

Dental History

Dentist Name:_____ Address _____ Phone _____

Dentist Specialist Name:_____ Address _____ Phone _____

Frequency of dental checkups: ☐Twice a year ☐ Once a Year ☐Only if a problem exists ☐Never Date of last Visit_____

Is there any unfinished care to be completed with your dentist? ☐No ☐ Yes	Explain:
Are you anxious about dental treatment? ☐ No ☐ Yes	Explain:
Have you had an unpleasant experience in a dental office? ☐ No ☐ Yes	Explain:
Have you had any facial or dental injuries? ☐ No ☐ Yes	Explain:
Do you play any musical instrument? ☐ No ☐ Yes	What instrument?
Have you consulted an orthodontist previously? ☐ No ☐ Yes	With whom?
Have teeth (either baby or permanent) been removed? ☐ No ☐ Yes	
Have you had any previous orthodontic treatment? ☐ No ☐ Yes	With whom?
Are you satisfied with prior treatment? ☐ No ☐Yes	Explain:
Have you noticed any changes in your bite or dental alignment recently? ☐ No ☐Yes	Explain:

What are the chief concerns you have related to the position of your teeth or bite?

☐ Aesthetic ☐ Cleaning ☐ Comfort ☐ Ability to chew ☐ Stability

Please elaborate:_____

What concerns has your dentist(s) expressed concerning your bite or dental alignment:

☐Wear or fractures of teeth ☐Difficulty with cleaning related to alignment of teeth

☐Bone or gum tissue loss ☐Jaw joints or muscle tightness or discomfort

☐Alignment of teeth prior to restorative dental work (crowns, bridges, etc.)

Other_____

Please check if there is a history of:

☐ Clenching teeth ☐ Muscular soreness around head and neck ☐ Jaw joint soreness ☐ Jaw joint popping

☐ Grinding teeth ☐ Headaches (more than normal) ☐ Jaw joint clicking ☐ Ringing in the ears

☐ Speech problems (If so, which sounds_____) ☐ Mouth breathing: Awake___ Asleep ___

Is there any other information that may be helpful?_____

Signature_____ Date _____ Reviewed by:_____