ORTHODONTIC PATIENT INFORMATION

PATIENT'S NAME: NICKNAME:

DATE OF BIRTH: AGE: GENDER:

ADDRESS:

HOME PHONE: E-MAIL:

SOCIAL SECURITY NUMBER: ____

CELL PHONE: CELL PHONE CARRIER: ____________________

EMPLOYER: ________________________ OCCUPATION:_______________

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

EmergencyContactName:____

EmergencyContactPhone#:_______________ Relationship:______________

GENERAL DENTIST:

REFERRED BY:

RESPONSIBLE PARTY: ☐ SELF ☐ OTHER

Name______________________________

Address____________________________

____

Phone#_____________________________

SocialSecurity#_______________________

Is patient coveredby insurance for orthodontic treatment? ☐ YES ☐ NO

____ ________________________

Signature Date

MEDICAL HISTORY

Physician:____ Date of Last Visit:______________

Address:____ Phone:________________________

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication?____

Yes No Are you allergic to any medication?____

Yes No Do you have a history of a major illness?_____________________________________

Yes No Have you had any operations?____

Yes No Have you ever smoked or chewed tobacco?____________________________________

Yes No Have seen a physician in the last 12 months? Why?____________________________

Yes No Female Patient Only: Has Menstruation started?________ Are you preganant:_________

Circle any of the medical conditions below that you have had or currently have:

Abnormal bleeding	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Hemophilia
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorder	HIV/Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney Problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of?____

DENTAL HISTORY

General Dentist:____________________________________ Date of last visit:______________________

What concerns you most about your teeth?____

Yes No Are you presently in any dental pain?____

Yes No Have you ever experienced any unfavorable reaction to dentistry?__________________

Yes No Have you ever lost or chipped any teeth?____

Yes No Have there been any injuries to face, mouth, or teeth?___________________________

Yes No Is any part of your mouth sensitive to temperature/pressure? Where?________________

Yes No Do you have any type of thumb or tongue habit?____________________________________

Yes No Have you ever seen an orthodontist? If yes, who and when?______________________

Yes No Has anyone in your family received orthodontic treatment?______________________

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning?_________

Yes No Are you aware of your jaw clicking or popping?____________________________________

Yes No Are you aware of clenching your teeth during the day? ______________________________

Yes No Have you ever been told that you grind your teeth?______________________________

Yes No Have you ever experienced chronic ringing in your ears?_________________________

Yes No Are you aware that some appointments will be during work hours?

Doctor's Signature____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. __________________ to perform a complete orthodontic evaluation.

Signature:____ Date:________________________

ORTHODONTIC INSURANCE INFORMATION

PATIENT NAME: **DOB:**

SUBSCRIBER'S NAME: ____

SUBSCRIBER'S ADDRESS: ____

____

SUBSCRIBER'S SOCIAL SECURITY NUMBER: ______________________

SUBSCRIBER'S DATE OF BIRTH: ________________________________

INSURED'S EMPLOYER: ____________________ **GROUP#:**___________

NAME OF INSURANCE COMPANY:______________________________

POLICY/CONTRACT #:______________________________________

INSURANCE CO MAILING ADDRESS: ____________________________

____

INSURANCE CO TELEPHONE #:________________________________

OFFICE USE ONLY:

IN ORDER TO PROCESS YOUR INSURANCE EFFECTIVELY, WE WILL CONTACT YOUR INSURANCE COMPANY AND OBTAIN THE FOLLOWING INFORMATION FOR ORTHODONTIC BENEFITS:

PERCENTAGE COVERED ___________**%** **LIFETIME MAX:**__________
AGE LIMIT:____
EFFECTIVE DATE:______________ **WAITING PERIOD: Y/N**
DEDUCTIBLE: $_____________ **CHECKS PAYABLE TO:**______________
PREVIOUS BENEFITS PAID): $_______ **REMAINING BENEFITS: $**________
PRE-AUTHORIZATION REQUIRED: Y/N **QUARTERLY VERIFICATION: Y/N**

I hereby authorize release of any information relating to this and any claim and payment directly to the above named orthodontist of the insurance benefits.

SIGNATURE: ____