WELCOME
TO THE ORTHODONTIST

The benefits of a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset.

Please fill out this form completely. The better we communicate, the better we can care for you.

1. ABOUT YOU

Today's Date:_____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate:_____/ _____/ _____ Age:_____ SS#: _____

Home Address: _____

_____
CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #:_____ Pager/Other #: _____

Wk #:_____ Ext:____ DL#: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we **Thank** for referring you? _____

Other family members seen by us: _____

General Dentist: _____ Last Visit Date: _____

Any Treatment Rendered? _____

2 SPOUSE INFORMATION

His/Her Name: _____

Employer: _____

Wk #: _____ Ext: _____ SS#: _____

Birthdate:_____/ _____/ _____

Person Responsible for Account: _____

Wk#: ( )_____ Ext:____ Hm#: ( ) _____

Billing Address: _____

Relation: _____ SS#: _____

Employer: _____ DL#: _____

3. ORTHODONTIC INSURANCE

Primary

Orthodontic Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: ( ) _____

Group # (Plan, Local or Policy#): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate:___/___/___ Insured's SS#:_____

Insured's Employer: _____

Secondary

Orthodontic Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: ( ) _____

Group # (Plan, Local or Policy#): _____

Insured's Name: _____

Insured's Birthdate:___/___/___ Insured's SS#:_____

Insured's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His/Her Name: _____ Relation: _____

Wk #: ( )_____ Hm#: ( )_____

4. MEDICAL HISTORY

Do you have a personal physician? ☐ YES ☐ NO

Physician's Name: _____

Phone #: ( ) _____

CONTINUED ON BACK

4. MEDICAL HISTORY *continued*

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐Yes ☐No

Please explain: _____

Are you taking any prescription/over the counter drugs? ☐Yes ☐No

Please list each one: _____

For Women: Are you taking birth control pills? ☐Yes ☐No

Are you pregnant? ☐ Yes ☐ No Week#: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Y N	Anemia/Radiation Treatment	Y N	Heart Surgery/Pacemaker
Y N	Artificial Bones/Joints	Y N	Hemophilia/Abnormal Bleeding
Y N	Artificial Valves	Y N	Hepatitis
Y N	Asthma Arthritis	Y N	High/Low Blood Pressure
Y N	Blood Transfusion	Y N	HIV+/AIDS
Y N	Cancer/Chemotherapy	Y N	Hospitalized for Any Reason
Y N	Congenital Heart Defect	Y N	Kidney Problems
Y N	Diabetes/Tuberculosis (TB)	Y N	Mitral Valve Prolapse
Y N	Difficulty Breathing	Y N	Psychiatric Problems
Y N	Drug/Alcohol Abuse	Y N	Rheumatic/Scarlet Fever
Y N	Emphysema/Glaucoma	Y N	Severe/Frequent Headaches
Y N	Epilepsy/Seizure/Fainting Spells	Y N	Shingles
Y N	Fever Blisters/Herpes	Y N	Sinus Problems
Y N	Heart Attack/Stroke	Y N	Ulcers/Colitis
Y N	Heart Murmur	Y N	Veneral Disease

Please list any serious medical condition(s) that you have ever had:

_____

Are you allergic to any of the following?

Y N	Aspirin	Y N	Dental Anesthetics	Y N	Penicillin
Y N	Any Metal/Plastic	Y N	Erythromycin	Y N	Tetracycline
Y N	Codeine	Y N	Latex	Y N	Other

5. DENTAL HISTORY

What are the main concerns that you would like orthodontics to accomplish?

_____

_____

_____

Have you ever been evaluated for orthodontic treatment? ☐ Yes ☐ No

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in you jaw joint (TMJ / TMD)? ☐Yes ☐No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐Yes ☐No

Do your gums bleed? ☐Yes ☐No

Have you ever had an injury to your: Mouth Teeth Chin

Do you have any speech problems?

_____

Do you generally breathe through your mouth? Y N Awake?
Y N Asleep?

Do you have any missing or extra permanent teeth? ☐Yes ☐No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature **Date**

Thank you for filling out this form completely.

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

_____

Signature Date

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICIAL USE ONLY OFFICIAL USE ONLY **OFFICIAL USE ONLY** OFFICIAL USE ONLY **OFFICIAL USE ONLY**

I verbally reviewed the medical / dental information above with the patient named herein.

Doctor's Comments: Initials: _____ Date: _____

_____

_____

_____

Acknowledgement of Receipt of Notice of Privacy Practices; Consents to Communications

TO BE COMPLETED BY THE PATIENT OR THE PATIENT'S PERSONAL REPRESENTATIVE (E.G., PATIENT'S PARENT OR LEGAL GUARDIAN)

Last Name _____ First Name _____ Middle Name _____

Date of Birth _____ Home Phone _____ Mobile Phone _____

Email Address _____ Patient Name (if completed by Personal Representative) _____

	Yes	No
I acknowledge receipt of this dental office's ("Practice") Notice of Privacy Practices.	☐	☐
I consent to receive recall appointment reminder information at the mailing address on file with the Practice.	☐	☐
I consent and agree to receive calls and text messages from or on behalf of the Practice and its affiliates at the home and/or mobile phone numbers provided above. These calls and text messages may include (but are not limited to) those concerning my health care, my account and insurance, and the Practice's services and may include marketing content. These calls and texts may be placed using automatic dialing or pre-recorded/artificial voice technology, and standard message or data rates may apply. I understand that my consent is voluntary and is not a required condition for receiving care from the Practice. I understand that I can unsubscribe at any time by calling the Practice or replying "STOP" to a text message from the Practice or its applicable affiliate.	☐	☐
I consent to receive voice messages from the Practice and its affiliates containing health information at the home and/or mobile phone numbers provided above.	☐	☐
I consent to receive email communications from or on behalf of the Practice and its affiliates at the email address provided above. I understand that these communications may include (but are not limited to) operational notices about my account and insurance and are part of my relationship with the Practice. I also understand that these communications may include promotional communications, including, but not limited to, newsletters, information about new services or suggested screenings, special offers, surveys and other news and information that the Practice thinks will be of interest to me. I understand that I may opt out of receiving promotional emails at any time by following the unsubscribe instructions provided therein. I understand that if I opt out of receiving promotional communications from the Practice, I may still receive transactional communications, including emails about my account or relationship with the Practice.	☐	☐

I permit the Practice to share appointment, billing, and general dental/health information with the following individual(s) who are involved in my (or, if I am the patient's personal representative, the patient's) care (*e.g.*, a family member, friend, caregiver):

_____

I understand that I may revoke any of the above consents at any time by so advising the Practice in writing. My revocation of any consent will not affect my (or, if I am the patient's personal representative, the patient's) ability to receive services from Practice.

Signature of Patient / Personal Representative _____ ***If Personal Representative, relationship to Patient*** _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

☐ Patient / Personal Representative refused to sign form ☐ Other: _____

Signature of Office Manager _____ Date _____

•Main Street•
Orthodontics

APPOINTMENT POLICY

Please be advised:

In order to avoid a broken appointment fee of $50.00, please call the office to cancel or reschedule all appointments that you are unable to commit to. You can do this by phone or in person in the office. This **MUST BE DONE AT LEAST 24 HOURS PRIOR TO THE APPOINTMENT.**

If you are an orthodontic patient (in braces) this could also delay your treatment and incur additional charges.

By signing below, I acknowledge that I understand and agree to the broken appointment policy.

_____ _____

PATIENT NAME **DATE**

_____

PATIENT SIGNATURE