

Today's Date: _____

How did you hear about us? (select all that apply, and provide details if room is provided)

☐ Facebook ☐ Instagram ☐ Our website ☐ Search Engine (e.g., Google): _____

☐ Friend: _____ ☐ Event: _____

☐ Dentist: _____ ☐ Other: _____

PATIENT INFORMATION

Patient Name: _____ (Prefers to be called: _____)

first last

Gender: _____ Birthdate: ____/____/____ School: _____ Grade: _____

month day year if applicable

if applicable

Phone: 1st # H C W (____) ____ - ____ 2nd # H C W (____) ____ - ____ 3rd # H C W (____) ____ - ____

circle one

circle one

circle one

Cell Carrier: _____

Cell Carrier: _____

Cell Carrier: _____

for cell phones only

for cell phones only

for cell phones only

Email: _____

Mailing Address: _____

if different

street address

city

postal code

Dentist: _____ Physician: _____

Other children in family: _____

name(s) and age(s)

RESPONSIBLE PARTIES

Adult patients: complete for yourself and/or your spouse, if either may have orthodontic insurance

Child patients: Please complete parental information

Mother Spouse Name: _____ Birthdate: ____/____/____

first

last

month day year

Self Mailing Address: _____

if different

street address

city

postal code

Phone #: H C W (____) ____ - ____ Employer: _____

circle one

Father Spouse Name: _____ Birthdate: ____/____/____

first

last

month day year

Self Mailing Address: _____

if different

street address

city

postal code

Phone #: H C W (____) ____ - ____ Employer: _____

circle one

MEDICAL HISTORY

Yes No

1. ☐ ☐ Does the patient smoke?
2. ☐ ☐ Does the patient have any *history* of major illness?
If yes, please explain: _____
3. ☐ ☐ Is the patient *presently* under the care of a physician for a major illness?
If yes, please explain: _____
4. ☐ ☐ Is the patient currently taking any medications?
If yes, please list: _____
5. ☐ ☐ Has the patient been advised to take antibiotics or other medications before dental visits?
If yes, please list: _____
6. ☐ ☐ Does the patient have allergies to any drugs?
If yes, please list: _____
7. ☐ ☐ Does the patient have any other allergies? (E.g., seasonal, food, etc.)
If yes, please list: _____
8. ☐ ☐ Has the patient had his/her tonsils removed?
If yes, at what age? _____
9. ☐ ☐ Has the patient had his/her adenoids removed?
If yes, at what age? _____
10. ☐ ☐ If tonsils and/or adenoids have not been removed, does the patient have regular problems with them? (or: ☐ not applicable)
If yes, please explain: _____
11. ☐ ☐ Is the patient prone to colds, sore throats, and/or ear infections?
If yes, which? _____
12. ☐ ☐ Does the patient have any physical or mental considerations? (E.g., ADHD, ASD, anxiety, etc.)
If yes, please explain: _____
13. ☐ ☐ Does the patient require any extra help during appointments, or with instructions?
If yes, please explain: _____
14. ☐ ☐ Female patients: Are you pregnant or trying to become pregnant? (or: ☐ not applicable)
15. ☐ ☐ Child patients: Has the patient reached puberty? (or: ☐ not applicable)
16. ☐ ☐ Is the patient up to date with his/her vaccinations?
If no, please explain: _____

17. Please select any of the following that the patient has had problems with:

- | | | | |
|--|--|---|--|
| ☐ Alzheimer's Disease | ☐ Anaphylaxis | ☐ Anemia | ☐ Asthma |
| ☐ Bleeding | ☐ Bone Disorders | ☐ Cleft Lip/Palate | ☐ Diabetes |
| ☐ Epilepsy/Seizures | ☐ Fainting/Dizziness | ☐ Hearing | ☐ Heart Murmur |
| ☐ Heart Trouble/Disease | ☐ Heart Valves | ☐ Hemophilia | ☐ Kidney Disease |
| ☐ Liver Disease | ☐ Nervous Disorder(s) | ☐ Pneumonia | ☐ Rheumatic Fever |
| ☐ Other: _____ | | | |

18. Please select any of the following that the patient has or has been exposed to:

- | | | | |
|------------------------------------|-----------------------------------|---------------------------------------|--------------------------------|
| ☐ Hepatitis | ☐ HIV/AIDS | ☐ Tuberculosis | ☐ STI's |
|------------------------------------|-----------------------------------|---------------------------------------|--------------------------------|

19. Please describe any other medical problems not yet covered:

****If the patient is currently experiencing pink eye, strep throat, mononucleosis, or another contagious illness, please contact our office before the new patient consultation to reschedule.**

DENTAL HISTORY

Yes No

20. ☐ ☐ What are the patient's/parent's concerns regarding the appearance of the patient's teeth?
If yes, please explain: _____
21. ☐ ☐ Does the family have a history of an underbite? I.e., the lower teeth extend outward further than the upper teeth. (or ☐ unsure)
If yes, what is the relationship to the patient? _____
22. ☐ ☐ Have there been any injuries to the face, teeth or jaw joints?
If yes, please explain: _____
23. ☐ ☐ Does the patient have speech problems?
If yes, has the patient had speech therapy? Please explain: _____
24. ☐ ☐ Has the patient ever sucked his/her thumb or fingers?
If yes, until what age? _____
25. ☐ ☐ Does the patient snore while sleeping? (or: ☐ unsure)
26. ☐ ☐ Does the patient breathe through the mouth, rather than the nose? (or: ☐ usually ☐ sometimes)
27. ☐ ☐ Are there any diagnosed or suspected airway/breathing problems, including sleep apnea?
If yes, please explain: _____
28. ☐ ☐ Has the patient been informed of any missing permanent teeth?
If yes, how many, and which teeth? _____
29. ☐ ☐ Has the patient had an orthodontic consultation previously?
If yes, when, where and for what type of orthodontic treatment? _____
30. ☐ ☐ Has either parent previously had orthodontic treatment?
If yes, which parent(s)? At which office(s)? _____
31. ☐ ☐ Does the patient experience pain in the jaw joint?
If yes, right and/or left side? _____
32. ☐ ☐ Does the patient have clicking in the jaw?
If yes, how often? _____
33. ☐ ☐ Has the patient ever been diagnosed with having jaw joint (TMJ) problems?
If yes, when? What has been done? _____
34. ☐ ☐ Does the patient chew on pens, pencils, fingernails, etc.?
35. ☐ ☐ Does the patient play a contact sport?
If yes, which sport? _____
36. ☐ ☐ Does the patient play a wind/brass instrument?
If yes, which instrument? _____
37. When was the patient last seen by his/her dentist? _____
38. What was done at the last dental visit? _____
39. When is the patient scheduled to return to his/her dentist? _____
40. How often does the patient see his/her dentist? _____

I understand that the information I have given is correct to the best of my knowledge, and it is my responsibility to inform the office of any changes in the health status of the patient.

Authorization is hereby granted for the orthodontic consultation and any necessary dental services that the patient may have during diagnosis and treatment with my informed consent.

Signature: _____ Date: _____

Relationship to patient: _____ Legal Guardian (if different): _____

INSURANCE BENEFITS

Please complete ALL of the insurance information below and bring with you to your appointment.

This appointment is complementary, but with this information we can help you to estimate the portion of any recommended treatment that may be covered by your insurance plan.

If you do not know what your insurance company covers, usually a quick phone call to the insurance company by the plan holder can answer these questions. Due to privacy laws in place by the companies unfortunately we are unable to call on your behalf. When you call please make sure to tell them you would like to know what your “**Orthodontic**” benefits cover.

Thank you for completing this information ahead of time. We look forward to meeting with you at your appointment.

Patient Name _____

Patient Birth Date _____

Primary Insured

Secondary Insured

Insured Name _____

Insured Name _____

Insured Birth Date _____

Insured Birth Date _____

Employer _____

Employer _____

Insurance Company _____

Insurance Company _____

Group/Plan/Policy # _____

Group/Plan/Policy # _____

ID/Certificate # _____

ID/Certificate # _____

Coverage % _____

Coverage % _____

Lifetime/Yearly Limit _____

Lifetime/Yearly Limit _____