WELCOME

1 ABOUT YOU

Today's Date: _____ /_____ /_____

Patient Name: _____

What you prefer to be called: _____ ❑ Male ❑ Female

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

Mailing Address: _____

_____

Home Phone #: (_____) _____

Work Phone #: (_____) _____ Ext _____

Cell Phone #: (_____) _____

Email Address: _____

_____

Occupation: _____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: _____

Do you have children? ❑ Male ❑ Female How many? _____

Has Dr. Jen treated any family members? ❑ Yes ❑ No

If yes, who_____

2 INSURANCE

Primary Dental Insurance

Does your insurance cover Adult Orthodontics? ❑ Yes ❑ No

If yes complete the following:

Dental Insurance Co. Name: _____

Address: _____

_____

Phone#: _____

Insured's ID #: _____

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

Insured's Name: _____

Relation: _____ Date of Birth: ____ /____ /____

Insured's Employer: _____

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.
Initials
I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

3 ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

_____

SS #: _____

Work Phone #: (_____) _____

4 IN EVENT OF EMERGENCY

Whom should we contact? _____

Relation: _____

Home Phone #: (_____) _____

Work Phone #: (_____) _____

Cell Phone #: (_____) _____

Who is patient's Medical Doctor or Pediatrician?

_____

Medical Doctor's Phone #: (_____) _____

Please Continue On Back

5 DENTAL INFORMATION

Please indicate any of the following problems:

❑ Discomfort, clicking or popping in jaw
❑ Red, swollen or bleeding gums
❑ Sensitive tooth, teeth or gums
❑ Blisters/Sores in or around the mouth
❑ Injuries to teeth/face
❑ Teeth Grinding
❑ MIssing Teeth
❑ Wisdom Teeth Removed
❑ Stained Teeth
❑ Wore Braces Previously
❑ Other: _____

Do you require pre-medication? ❑ Yes ❑ No ❑ Don't know

Dentist: _____ (_____) _____

Last Dental Exam: ____ /____ /____

Times a day you brush? _____ Times a week you floss? _____

How would you rate your smile? **Best** 1 2 3 4 5 6 7 8 9 10 **Worst**

6 PATIENTS MEDICAL HISTORY

Describe any current medical treatment you are undergoing:

_____

_____

Physician: _____ (_____) _____

Do you have or ever had any of the following diseases, medical conditions or procedures? Check all that apply:

❑ Heart Murmur
❑ Rheumatic Fever
❑ Artificial Heart Valves
❑ Congenital Heart defect
❑ Scarlet Fever
❑ Surgeries/Operations
❑ Cancer/Tumors/Chemotherapy
❑ Pregnancy
❑ Jaw Problems TMJ/TMD
❑ Hearing Problems
❑ Tonsillitis
❑ Respiratory Problems
❑ Asthma/Difficulty Breathing
❑ Blood Transfusion(s)
❑ Leukemia/Anemia
❑ Diabetes/Hypoglycemia
❑ Hemophilia
❑ Abnormal Bleeding
❑ Cleft Lip/Palate
❑ Birth Defects
❑ High/Low Blood Pressure
❑ Hepatitis
❑ Artificial Bones/Joints/Implants
❑ Liver/Kidney/Organ Problems
❑ HIV+/AIDS/ARC
❑ Tuberculosis TB
❑ Psychiatric Problems
❑ Hyper Active/ADD
❑ Fainting/Seizures/Epilepsy
❑ Cerebral Palsy

Please list any medications currently taking: _____

_____

Are you allergic to: ❑ Latex ❑ Nickel ❑ Motrin/Ibuprofen ❑ Food Allergies ❑ Other

Existing or Past Habits: ❑ Thumb/Finger Sucking ❑ Tongue Thrusting
❑ Heavy Snoring ❑ Mouth Breathing ❑ Lip Sucking/Biting ❑ Smoking/Chewing Tobacco

- We invite you to discuss with us any questions regarding our services. The best Orthodontic dental services are based on a friendly, mutual understanding between provider and patient.
- Consent to Dental Photography: I agree & consent to allow photographs taken before, during and after completion of my orthodontic treatment to be used for dental records, public relations, patient counseling or other purposes.
- Consent to Dental Radiographs: Please note our xray equipment exposes our patients to minimal radiation. For example, one panoramic xray equals 2 hours of TV watching. Your safety is our top priority.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ Date: ____ /____ /____

❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE
(OFFICE USE)

_____ ___/___/___
Initials Date

_____
Comments

_____ ___/___/___
Initials Date

_____
Comments

_____ ___/___/___
Initials Date

_____
Comments