PATIENT INFORMATION

A+ A A- B+ B B- C

Date_____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home # _____ Birthdate _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

How did you hear about us? Check all that apply ☐ A Friend _____ ☐ Internet Search _____ ☐ Our Website
Who? ie) Google

☐ Social Media _____ ☐ Billboard _____ ☐ Radio _____ ☐ Magazine _____
Which One? Located Where? Station # Which One?

☐ Newspaper _____ ☐ Yellow Pages _____ ☐Other _____
Which One? Which One? Explain

RESPONSIBLE PARTY INFORMATION

Name _____ Marital Status _____
Last First Middle

Residence Address _____ ☐ Own or ☐ Rent
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address? _____ Home # _____ Work # _____

Cell # _____ Email address _____ (we notify you of next appt by text/email)

Previous address if less than 3 years _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to patient _____

Employer _____ Occupation _____ No. Yrs. Employed _____

Spouse's Name _____ Relationship to patient _____
Last First Middle

Employer _____ Occupation _____ No. Yrs. Employed _____

Social Security # _____ Birthdate _____Work #_____

DENTAL INSURANCE INFORMATION

Insured's Name _____ Insured's Social Sec. # _____
Last First Middle

Insured's Address (if different from above) _____
Street City State Zip

Employer & Address _____

Insured's Birthdate _____ Home # _____ Work # _____

Insurance Co. Name & Phone # _____

Insurance Co. Address _____
Street City State Zip

Insurance ID # _____ Group # _____ Local # _____

Do you have dual coverage? Yes _____ No _____ If yes:

Insured's Name _____ Insured's Social Sec. # _____
Last First Middle

Insured's Address (if different from above): _____
Street City State Zip

Insured's Birthdate _____ Home # _____ Work # _____

Insurance Co. Name & Phone # _____

Insurance Co. Address _____
Street City State Zip

Insurance ID #_____ Group #_____ Local #_____

EMERGENCY CONTACT INFORMATION – not shared with anyone

Name of nearest relative not living with you _____

Complete Address _____

Home # _____ Cell # _____ Email address _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____ Date_____

PERSONAL INFORMATION

Nickname we may call the patient_____ Age_____ Sex_____ Height_____ Weight_____

Dentist_____ Physician_____ School, if child_____ Grade_____

Favorite Sports or Hobbies_____ Musical instruments played_____

Does the patient have any personal problems or objections regarding wearing braces? _____

Has any other member of the family had orthodontic treatment? If so, where? _____

What is the main reason you need to see an orthodontist? _____

MEDICAL HISTORY

For the following questions please ***circle*** Yes, No, or don't know/understand (dk/u) to all answers that apply. Please **explain** all yes answers. The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

Yes No dk/u	Birth defects or hereditary problems?	Yes No dk/u	Cardiovascular problem (heart trouble, heart attack,
Yes No dk/u	Major Accidents?		angina, coronary insufficiency, arteriosclerosis, stroke,
Yes No dk/u	Rheumatoid or Arthritic conditions?		inborn heart defects or rheumatic heart?
Yes No dk/u	Endocrine or thyroid problems?		Describe condition: _____
Yes No dk/u	Diabetes	Yes No dk/u	Allergies or Drug reactions? List:_____
Yes No dk/u	Kidney problems?		_____
Yes No dk/u	Cancer or tumor?	Yes No dk/u	Is the patient taking any type of prescription or non -
Yes No dk/u	Stomach Ulcer?		prescription medication? If so, please list them.
Yes No dk/u	Aids or HIV positive?		_____
Yes No dk/u	Mental health, behavior or emotional problems, ADD or hyperactive condition?	Yes No dk/u	Being treated by another health care professional? For: _____
Yes No dk/u	High or low blood pressure?	Yes No dk/u	Has the patient ever been treated with antibiotics prior to a routine dental appointment?_____
Yes No dk/u	Females: Is it possible you could be pregnant? Due date?_____	Yes No dk/u	Is there any other medical or emotional condition you feel we should be made aware of that would prevent the
Yes No dk/u	Has the patient ever taken any Bone Strengthening Medicines? _____		patient from following instructions? _____ _____

DENTAL HISTORY

Yes No dk/u	Is the patient presently in any dental pain?	Yes No dk/u	Any history of injuries to the face, mouth, or teeth?
Yes No dk/u	Thumb or finger sucking habit? Until age _____	Yes No dk/u	Any relative with similar tooth or jaw relationship?
Yes No dk/u	Mouth breathing or snoring?	Yes No dk/u	Is the patient fearful of dental treatment?
Yes No dk/u	Pain or soreness in the muscles of the face?	Yes No dk/u	Has the patient ever had a "whiplash" injury?
Yes No dk/u	Jaw joint popping, clicking, or locking?	Yes No dk/u	History of Tempromandibular Joint Disorder, TMJ?
Yes No dk/u	Has any relative had jaw repositioning surgery?		
Yes No dk/u	Onset of puberty (approximate date)? _____	Yes No dk/u	Does patient need extra help with instructions?
Yes No dk/u	Has the patient ever had <u>prior</u> orthodontic treatment		
	or examination? When and Where? _____		Date of most recent dental exam?_____

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 dental health, and in the general function of the teeth. Teeth, gums, and jaws are intricate body parts and can fail to respond to treatment. Successful treatment greatly depends on the patient completely following instructions, keeping appointments and maintaining good oral hygiene. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Jaw joint discomfort due to clenching and tooth root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth if retainers are not worn as prescribed. 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. Rice to perform a complete orthodontic evaluation.

Signature (Parent's Signature if minor) _____ Date_____

Treatment Coordinator _____