

smile more

ORTHODONTICS

www.smilemoreortho.com

1. ABOUT YOU

Today's Date _____ Date of Birth _____

Name _____ Age _____

Last _____ First _____ MI _____ Mr./Mrs./Ms. _____

I prefer to be called _____

Home # _____

Work # _____ Cell # _____

Social Security # _____

Driver's License # _____

Email Address _____

Home Address _____

Apt. # _____

City _____ State _____ Zip _____

When and Where are the best times to reach you?

Other family members seen by us:

How did you hear about our office?

2. ABOUT YOUR EMPLOYER

Name _____

Address _____

How long have you worked there? _____

Occupation _____

3. SPOUSE INFORMATION

(If Applicable)

Name _____

Employer _____

Work # _____ Cell # _____

Date of Birth _____

Social Security # _____

Email Address _____

DENTAL INFORMATION

Present Dentist _____

Street _____

Phone # _____ Last Visit _____

4. RESPONSIBLE PARTY INFO

Name _____

Billing Address _____

City _____ State _____ Zip _____

Home # _____

Cell # _____

Employer _____

Work # _____

Date of Birth _____

Social Security # _____

Email Address _____

EMERGENCY CONTACT

Name _____

Relation _____

Work # _____

Home # _____

5. PRIMARY DENTAL INSURANCE

Ins. Name _____

Ins. Address _____

Insurance Co. Phone # _____

Group/Policy # _____

Insured's Name _____

Relationship to Patient _____

Insured's DOB _____

Insured's Employer _____

Social Security # _____

Orthodontic Coverage: YES NO

SECONDARY DENTAL INSURANCE

Ins. Name _____

Ins. Address _____

Insurance Co. Phone # _____

Group/Policy # _____

Insured's Name _____

Relationship to Patient _____

Insured's DOB _____

Insured's Employer _____

Social Security # _____

Orthodontic Coverage: YES NO

6. DENTAL HISTORY

Why have you come to the Orthodontist today?

Are you currently in pain? Y N

Your current Dental Health is:

Good Fair Poor

Have you ever had a serious/difficult problem associated with previous dental work? Y N

Have you ever had any pain or tenderness in the jaw joint (TMJ/TMD)? Y N

Do you like your smile? Y N

Do your gums ever bleed? Y N

How many times a week do you floss? _____

How many times a day do you brush? _____

Types of bristles? Hard Medium Soft

7. MEDICAL HISTORY

Do you have a personal Physician? Y N

Name _____

Phone # _____ Last Visit _____

Your current physical health is:

Good Fair Poor

Are you currently under the care of a doctor?

Y N Explain: _____

Are you taking any prescription drugs? Y N

FOR WOMEN ONLY

Are you taking birth control pills? Y N

Are you pregnant? Y N

Are you nursing? Y N

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

Y N Prosthesis Y N History of Scarlet Fever

Y N Heart Attack Y N Congenital Heart Def.

Y N Cancer Y N Convulsions/Epilepsy

Y N Diabetes Y N Abnormal Bleeding

Y N Rheum. Fever Y N Artificial Valves

Y N HIV+/AIDS Y N Heart Surgery/Pacemaker

Y N Hemophilia Y N Any Stays in Hospital

Y N Asthma Y N Kidney/Liver Problems

Y N Hepatitis Y N Mitral Valve Prolapse

Y N Tuberculosis Y N Artificial Bones/Joints

Y N Shingles Y N Sev./Freq. Headaches

Y N Fever Blister Y N Hi/Lo Blood Pressure

Y N Venereal Dis. Y N Drug/Alcohol Abuse

Y N Ulcers/Colitis Y N Blood Transfusion

Y N Heart Murmur Y N Anemia/Radiation Tmt.

Y N Sinus Problems Y N Difficulty Breathing?

Y N Glaucoma Y N Other: _____

Please discuss if you answered "Yes" to any of the above or any other serious medical problems that you have had: _____

Are you allergic to any of the following?

Y N Aspirin Y N Erythromycin

Y N Codeine Y N Dental Anesthetics

Y N Latex Y N Tetracycline

Y N Penicillin Y N Other: _____

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

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

Signature _____ Date _____

Payment is DUE IN FULL at time of treatment unless prior arrangements have been approved.