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.

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