Stay Smiling ORTHODONTICS

WELCOME TO OUR OFFICE!

Please fill in the appropriate information.

Date: _____

Name: _____ Nickname: _____

Address: _____ Home Phone:

_____

City, State, Zip: _____ Birthdate:_____

Age: _____ Sex: _____

Marital Status: Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐

E-Mail (for appointment reminders) _____

Employer: _____ Business Phone _____

Occupation: _____ Cell Phone:_____

SS#_____

Spouse's Name:_____ Business Phone:_____

Employer: _____ Cell Phone: _____

Occupation: _____

SS#_____

Children (give names and dates of birth)_____

_____

Person Responsible for Account: _____SS#_____

(If different than above information)

Do you have Dental / Orthodontic insurance? ☐ Yes ☐ No

If yes, please complete the insurance information form to assist in the verification benefits.

Do you use a Reimbursement Account? ☐ Yes ☐No (Flex Plan, Cafeteria Plan)

Patient's General Dentist: _____ **Dentist's Phone :** _____

Patient's Physician: _____ Physician's Phone:_____

Whom may we thank for referring you? _____

Relatives treated here:_____

Has there been any previous orthodontic consultation or treatment? _____

Chief reason treatment is being sought? _____

DENTAL HISTORY	Yes	No
Has patient ever sucked his or her thumb or fingers?	☐	☐
Does patient breathe through the mouth more than through the nose	☐	☐
Have you been informed of any missing permanent teeth?	☐	☐
Have you been informed of any extra teeth?	☐	☐
	☐	
Have any teeth been injured due to accidents or falls?	☐	☐
Has the patient had any severe head or facial injuries?	☐	☐
Is the patient especially apprehensive toward dental visits?	☐	☐
Does the patient have a history of pain, clicking or popping of jaw joint?	☐	☐

MEDICAL HISTORY (√ check which apply)

Heart trouble ☐	Anemia ☐	Frequent headaches ☐
Kidney problems ☐	Hepatitis ☐	HIV positive or AIDS ☐
Emotional problems ☐	Allergies ☐	Asthma/hay fever ☐
Rheumatic fever ☐	Diabetes ☐	Tonsils/adenoids removed
Prolonged bleeding. ☐	Pregnant ☐	Wear contact lenses ☐
Fainting or dizziness. ☐	Epilepsy ☐	Frequent canker sores or
Latex allergy ☐		or fever blister ☐

NONE APPLY ☐

Other serious illnesses (specify):

_____

List any drugs or medications now being taken:_____

►I certify that the information provided on this form is correct to the best of my knowledge.

►I consent to the taking of diagnostic radiographs, photographs, and study models before, during and after treatment, and to the use of the same by the doctor in scientific papers or demonstrations.

► I authorize release of any information including diagnosis and record of any treatment of the above named patient to third party payors and/or health practitioners.

►I authorize and request my insurance company (if applicable) to pay directly to the office any insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be financially responsible for payment of all services rendered on my behalf.

_____ _____

RESPONSIBLE PARTY (LEGAL GUARDIAN) DATE