



FOR ADULTS: WELCOME TO OUR PRACTICE

Date: _____ OPMS#: _____

Doctor: **CY** **D** **S** **P**

Location: **J** **F** **M** **P** **B** **NL**

Exam With: _____

PATIENT INFORMATION

PATIENT NAME: _____ SS#: _____ DOB: _____ AGE: _____

PREFERRED NAME: _____ EMAIL: _____ MALE FEMALE

ADDRESS: _____ PHONE: (____) _____ CELL: (____) _____

CITY: _____ STATE: _____ ZIP: _____ SCHOOL/EMPLOYER: _____

HOBBIES/SPECIAL INTERESTS: _____

NAME OF GENERAL DENTIST: _____ PHONE: (____) _____

NAME OF OTHER FAMILY MEMBERS TREATED AT ASSOCIATED ORTHODONTISTS: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

ADDITIONAL RESPONSIBLE PARTY INFORMATION

NAME: _____ RELATIONSHIP: _____

BIRTHDAY: _____ SS#: _____ ADDRESS: _____

EMAIL: _____ PHONE: (____) _____ CELL: (____) _____

EMPLOYER: _____

EMERGENCY CONTACT: _____ PHONE: (____) _____

PRIMARY DENTAL INSURANCE

INSURANCE CO. NAME: _____

INSURANCE PHONE: _____

GROUP/POLICY #: _____

INSURED'S NAME: _____

RELATIONSHIP TO PATIENT: _____

INSURED'S DOB: _____

SS#/ID#: _____

INSURED'S EMPLOYER: _____

SECONDARY DENTAL INSURANCE

INSURANCE CO. NAME: _____

INSURANCE PHONE: _____

GROUP/POLICY #: _____

INSURED'S NAME: _____

RELATIONSHIP TO PATIENT: _____

INSURED'S DOB: _____

SS#/ID#: _____

INSURED'S EMPLOYER: _____

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

SIGNATURE: _____ DATE: _____

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

SIGNATURE: _____ DATE: _____

PATIENT DENTAL/MEDICAL HISTORY

WHY HAVE YOU COME TO THE ORTHODONTIST TODAY? _____

DO YOU LIKE YOUR SMILE? _____ YES NO

ARE YOU CURRENTLY IN PAIN? _____ YES NO

YOUR CURRENT DENTAL HEALTH IS: _____ GOOD FAIR POOR

HAVE YOU EVER HAD ANY SERIOUS/DIFFICULT PROBLEM ASSOCIATED WITH PREVIOUS DENTAL WORK?
 _____ YES NO

HAVE YOU EVER HAD ANY PAIN OR TENDERNESS IN THE JAW JOINT? _____ YES NO

HAVE YOU EVER HAD ANY TRAUMA TO THE MOUTH OR JAW JOINT? _____ YES NO

PLEASE DESCRIBE TRAUMA: _____

DO YOUR GUMS EVER BLEED? _____ YES NO

HOW MANY TIMES A WEEK DO YOU FLOSS? _____

HOW MANY TIMES A WEEK DO YOU BRUSH? _____

TYPES OF BRISTLES: _____ HARD MEDIUM SOFT

DO YOU HAVE A PERSONAL PHYSICIAN? _____ YES NO

NAME: _____ PHONE #: _____

YOUR CURRENT PHYSICAL HEALTH IS: _____ GOOD FAIR POOR

ARE YOU CURRENTLY UNDER THE CARE OF A DOCTOR? _____ YES NO

EXPLAIN: _____

ARE YOU TAKING ANY PRESCRIPTION DRUGS? _____ YES NO

LIST: _____

<table border="0"> <tr> <td style="width: 50%;">YES</td> <td style="width: 50%;">NO</td> </tr> <tr> <td><input type="checkbox"/> HEART MURMUR</td> <td><input type="checkbox"/> CANCER</td> </tr> <tr> <td><input type="checkbox"/> DIABETES</td> <td><input type="checkbox"/> RHEUMATIC FEVER</td> </tr> <tr> <td><input type="checkbox"/> HIV+/AIDS</td> <td><input type="checkbox"/> HEMOPHILIA</td> </tr> <tr> <td><input type="checkbox"/> ASTHMA</td> <td><input type="checkbox"/> HEPATITIS</td> </tr> <tr> <td><input type="checkbox"/> TUBERCULOSIS</td> <td><input type="checkbox"/> HEART ATTACK</td> </tr> <tr> <td><input type="checkbox"/> KIDNEY/LIVER PROBLEMS</td> <td><input type="checkbox"/> SHINGLES</td> </tr> <tr> <td><input type="checkbox"/> FEVER BLISTER</td> <td><input type="checkbox"/> VENEREAL DISEASE</td> </tr> <tr> <td><input type="checkbox"/> ULCERS/COLITIS</td> <td><input type="checkbox"/> EMPHYSEMA</td> </tr> <tr> <td><input type="checkbox"/> SINUS PROBLEMS</td> <td><input type="checkbox"/> PROSTHESIS</td> </tr> <tr> <td><input type="checkbox"/> DIFFICULTY BREATHING</td> <td></td> </tr> </table>	YES	NO	<input type="checkbox"/> HEART MURMUR	<input type="checkbox"/> CANCER	<input type="checkbox"/> DIABETES	<input type="checkbox"/> RHEUMATIC FEVER	<input type="checkbox"/> HIV+/AIDS	<input type="checkbox"/> HEMOPHILIA	<input type="checkbox"/> ASTHMA	<input type="checkbox"/> HEPATITIS	<input type="checkbox"/> TUBERCULOSIS	<input type="checkbox"/> HEART ATTACK	<input type="checkbox"/> KIDNEY/LIVER PROBLEMS	<input type="checkbox"/> SHINGLES	<input type="checkbox"/> FEVER BLISTER	<input type="checkbox"/> VENEREAL DISEASE	<input type="checkbox"/> ULCERS/COLITIS	<input type="checkbox"/> EMPHYSEMA	<input type="checkbox"/> SINUS PROBLEMS	<input type="checkbox"/> PROSTHESIS	<input type="checkbox"/> DIFFICULTY BREATHING		<table border="0"> <tr> <td style="width: 50%;">YES</td> <td style="width: 50%;">NO</td> </tr> <tr> <td><input type="checkbox"/> CONGENITAL HEART DEFECT</td> <td><input type="checkbox"/> CONVULSIONS/EPILEPSY</td> </tr> <tr> <td><input type="checkbox"/> ABNORMAL BLEEDING</td> <td><input type="checkbox"/> HEARING IMPAIRMENT</td> </tr> <tr> <td><input type="checkbox"/> ANY OPERATIONS</td> <td><input type="checkbox"/> ANY STAYS IN HOSPITAL</td> </tr> <tr> <td><input type="checkbox"/> HANDICAPS/DISABILITIES</td> <td><input type="checkbox"/> ALLERGIES TO ANY DRUGS</td> </tr> <tr> <td><input type="checkbox"/> HISTORY OF SCARLET FEVER</td> <td><input type="checkbox"/> ARTIFICIAL VALVES</td> </tr> <tr> <td><input type="checkbox"/> HEART SURGERY/PACEMAKER</td> <td><input type="checkbox"/> MITRAL VALVE PROLAPSE</td> </tr> <tr> <td><input type="checkbox"/> ARTIFICIAL BONES/JOINTS</td> <td><input type="checkbox"/> SEVERE/FREQUENT HEADACHES</td> </tr> <tr> <td><input type="checkbox"/> HI/LOW BLOOD PRESSURE</td> <td><input type="checkbox"/> DRUG/ALCOHOL ABUSE</td> </tr> <tr> <td><input type="checkbox"/> BLOOD TRANSFUSION</td> <td><input type="checkbox"/> ANEMIA/RADIATION TX</td> </tr> <tr> <td><input type="checkbox"/> GLAUCOMA</td> <td></td> </tr> </table>	YES	NO	<input type="checkbox"/> CONGENITAL HEART DEFECT	<input type="checkbox"/> CONVULSIONS/EPILEPSY	<input type="checkbox"/> ABNORMAL BLEEDING	<input type="checkbox"/> HEARING IMPAIRMENT	<input type="checkbox"/> ANY OPERATIONS	<input type="checkbox"/> ANY STAYS IN HOSPITAL	<input type="checkbox"/> HANDICAPS/DISABILITIES	<input type="checkbox"/> ALLERGIES TO ANY DRUGS	<input type="checkbox"/> HISTORY OF SCARLET FEVER	<input type="checkbox"/> ARTIFICIAL VALVES	<input type="checkbox"/> HEART SURGERY/PACEMAKER	<input type="checkbox"/> MITRAL VALVE PROLAPSE	<input type="checkbox"/> ARTIFICIAL BONES/JOINTS	<input type="checkbox"/> SEVERE/FREQUENT HEADACHES	<input type="checkbox"/> HI/LOW BLOOD PRESSURE	<input type="checkbox"/> DRUG/ALCOHOL ABUSE	<input type="checkbox"/> BLOOD TRANSFUSION	<input type="checkbox"/> ANEMIA/RADIATION TX	<input type="checkbox"/> GLAUCOMA	
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OTHER: _____

FOR WOMEN ONLY

ARE YOU TAKING BIRTH CONTROL PILLS? YES NO

ARE YOU PREGNANT? YES NO WEEK #: _____

ARE YOU NURSING? YES NO

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

ASPIRIN	<input type="checkbox"/> YES <input type="checkbox"/> NO	ERYTHROMYCIN	<input type="checkbox"/> YES <input type="checkbox"/> NO
CODEINE	<input type="checkbox"/> YES <input type="checkbox"/> NO	TETRACYCLINE	<input type="checkbox"/> YES <input type="checkbox"/> NO
LATEX	<input type="checkbox"/> YES <input type="checkbox"/> NO	OTHER: _____	
PENICILLIN	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	

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.

SIGNATURE: _____ DATE: _____