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: ______

EMERGENCY CONTACT: ______ PHONE: (____) ______

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: ______

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: ______

PLEASE COMPLETE SIDE 2

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: ______________________________________

____

YES	NO		YES	NO	
❑	❑	HEART MURMUR	❑	❑	CONGENITAL HEART DEFECT
❑	❑	CANCER	❑	❑	CONVULSIONS/EPILEPSY
❑	❑	DIABETES	❑	❑	ABNORMAL BLEEDING
❑	❑	RHEUMATIC FEVER	❑	❑	HEARING IMPAIRMENT
❑	❑	HIV+/AIDS	❑	❑	ANY OPERATIONS
❑	❑	HEMOPHILIA	❑	❑	ANY STAYS IN HOSPITAL
❑	❑	ASTHMA	❑	❑	HANDICAPS/DISABILITIES
❑	❑	HEPATITIS	❑	❑	ALLERGIES TO ANY DRUGS
❑	❑	TUBERCULOSIS	❑	❑	HISTORY OF SCARLET FEVER
❑	❑	HEART ATTACK	❑	❑	ARTIFICIAL VALVES
❑	❑	KIDNEY/LIVER PROBLEMS	❑	❑	HEART SURGERY/PACEMAKER
❑	❑	SHINGLES	❑	❑	MITRAL VALVE PROLAPSE
❑	❑	FEVER BLISTER	❑	❑	ARTIFICIAL BONES/JOINTS
❑	❑	VENEREAL DISEASE	❑	❑	SEVERE/FREQUENT HEADACHES
❑	❑	ULCERS/COLITIS	❑	❑	HI/LOW BLOOD PRESSURE
❑	❑	EMPHYSEMA	❑	❑	DRUG/ALCOHOL ABUSE
❑	❑	SINUS PROBLEMS	❑	❑	BLOOD TRANSFUSION
❑	❑	PROSTHESIS	❑	❑	ANEMIA/RADIATION TX
❑	❑	DIFFICULTY BREATHING	❑	❑	GLAUCOMA

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	❑ YES ❑ NO	ERYTHROMYCIN	❑ YES ❑ NO
CODEINE	❑ YES ❑ NO	TETRACYCLINE	❑ YES ❑ NO
LATEX	❑ YES ❑ NO	OTHER: ______________	
PENICILLIN	❑ YES ❑ 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: ______________

OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC, AND THE ADA.