

WELCOME TO OUR OFFICE

DATE _____
Updated _____
Updated _____

PATIENT'S NAME _____		NICKNAME _____	
D.O.B. _____	AGE _____	SEX M _____ F _____	
ADDRESS _____		TOWN _____	STATE _____ ZIP _____
HOME PHONE: _____		Cell/Work PHONE _____	
OCCUPATION _____		EMPLOYED BY _____	
EMAIL _____			

PERSON RESPONSIBLE FOR THIS ACCOUNT _____

DO YOU HAVE AN ORTHODONTIC INSURANCE PLAN? YES ___ NO ___

NAME OF INSURANCE COMPANY? _____

GROUP # _____

(note: We ONLY accept DELTA DENTAL ins. but we will provide you with a "superbill" for you to send into your particular insurance company)

GENERAL APRAISAL Who can we thank for your referral? _____

CHIEF COMPLAINT (REASON FOR CONSULTATION) _____

HAVE YOU HAD PREVIOUS ORTHODONTIC TREATMENT? ___NO ___YES IF YES,

EXPLAIN _____

MEDICAL HISTORY

PHYSICIAN _____ LAST EXAM _____

CURRENTLY UNDER MEDICAL TREATMENT ___NO YES___ explain _____

HISTORY OF RECENT ILLNESS ___NO YES___ explain _____

CURRENTLY TAKING MEDICATION ___NO YES___ explain _____

EVER BEEN HOSPITALIZED ___NO YES___ explain _____

EVER HAD AN OPERATION ___NO YES___ explain _____

ALLERGIC TO MEDICATIONS ___NO YES___ explain _____

ANY OTHER ALLERGIES ___NO YES___ explain _____

DO YOU HAVE A HISTORY OF:

ANEMIA BONE DISORDERS EPILEPSY
 ASTHMA KIDNEY DISORDERS RHEUMATIC FEVER
 DIABETES LIVER INVOLVEMENT BLEEDING

PROBLEMS:

HEART FAINTING OR DIZZINESS
 ENDOCRINE DISORDERS

EXPLAIN _____

DENTAL HISTORY

DENTIST _____ LAST EXAM _____

THUMB/FINGER SUCKING UNTIL AGE _____
 MOUTHBREATHING _____ AWAKE _____ ASLEEP
 GRINDING OR CLENCHING _____ DAY _____ NIGHT
 NAIL-BITING
 LIP BITING/LICKING
 BLEEDING GUMS
 INJURIES TO FACE/MOUTH/TEETH
 SORENESS OR CLICKING IN JOINT NO YES

HOW FREQUENTLY DO YOU USE FLOSS _____

HAVE YOU BEEN INFORMED OF ANY EXTRA OR MISSING TEETH? _____

ANY FURTHER COMMENTS: