



OUR MISSION STATEMENT

Our team is dedicated to providing excellent service and top quality treatment results in a caring, hospitable and safe environment while enhancing self-esteem by producing beautiful smiles for our patients.

1 ABOUT YOU

Patient's name	Sex	Birthday	Age
Address	City	State	Zip
Home Phone	Cell Phone	Patient's dentist	
Marital status: Married Divorced Single	SS#	email	
Special interests, sports or hobbies?			
Children's names and ages			
Have we seen any family member before? Y N	If so, patient's name		
Employer	Address	Phone	
Occupation			
Orthodontic insurance? Y N	Insurance company name		
Insurance company address			
I.D.#	Group #		
Limits of orthodontic coverage \$			
How did you hear about our office?			

SPOUSE INFORMATION

Spouse's name	SS#	email	
Address	City	State	Zip
Employer	Occupation		
Business address	Business phone		
Orthodontic insurance? Y N	Insurance company name		
Insurance company address			
I.D.#	Group #		
Limits of orthodontic coverage \$			

2 ACCOUNT RESPONSIBILITY

Person responsible for account	Address
I acknowledge that where appropriate a Credit Bureau report may be obtained.	
Signature	

Thank you for taking the time to fill out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

3 MEDICAL AND DENTAL HISTORY

Please circle Y or N for each question

Y N Have you had tonsils and adenoids removed? When?

Y N Do you have any endocrine (hormone) disturbances? (eg. diabetes, thyroid, etc.)

Y N Do you bleed for a prolonged period when cut or after tooth extractions?

Y N Do you have any heart, lung, kidney or digestive tract problems? Which?

Y N Are you taking any medications now? Please list.

Y N Are you allergic to any medications? Please list.

Y N Are you allergic to any metals or latex? Which?

Y N Do you suffer from asthma or bronchitis?

Y N Have you ever had seizures? Medications?

Y N Have you ever been under the care of a physician for illness? Please list.

Y N Have you ever had rheumatic fever?

Y N Have you ever had a positive test for HIV, AIDS, or Hepatitis?

Y N Have any teeth ever been extracted?

Y N Are you aware of any missing or extra teeth?

Y N Have you ever suffered any injury to the face? What and when?

Y N Have any teeth been injured due to an accident or fall?

Y N Are you apprehensive toward dental visits?

Y N Do you play a musical instrument with the mouth? Which instrument?

Y N Are you willing to wear braces if needed?

Y N Does your jaw ever pop or make noise? (if so, please ask to fill out an additional information sheet)

Y N Has your physician ever prescribed medication to strengthen your bones or to prevent or treat osteoporosis?

Y N Have you ever taken Actonel, Aredia, Boniva, Didronel, Fosamax, Skelid, Zometa, or any other Bisphosphate drug?

What do you feel are the main problems with your teeth and/or bite?

How do you feel orthodontics can help?

4 SIGNATURE

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Date _____ Signature of parent or guardian _____

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