WELCOME TO THE ORTHODONTIST

The benefits of a happy healthy smile are immeasurable!
A beautiful smile is a wonderful asset.

PRECISION ORTHODONTICS

PLEASE FILL OUT THIS FORM COMPLETELY. *The better we communicate, the better we can care for you.*

ABOUT YOU

Today's Date: _____/_____/_____

NAME: ❑MR ❑MRS ❑MS ❑DR _____
First M Last

I prefer to be called: _____ ❑ Male ❑ Female

Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

E-Mail Address: _____

Date of Birth: _____/_____/_____ Age: _____ SS#: _____

Home Address: _____
Street Address Apt/Condo #

_____
CITY STATE ZIP

Contact #s: Home #: (_____)_____ Mobile #: (_____)_____

Work #: (_____)_____ Drive License #: _____

Employer: _____

Employer's Address: _____
Street Address Suite #

_____
CITY STATE ZIP

Occupation: _____ How long there? _____

Where and when are best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

General Dentist: _____ Last Visit Date: _____/_____/_____

SPOUSE INFORMATION

Name: ❑MR ❑MRS ❑MS ❑DR _____
First M Last

Employer: _____

Work #: (_____)_____ ext: _____

SS#: _____ Date of Birth: _____/_____/_____

PERSON RESPONSIBLE FOR ACCOUNT:

Name: _____

Work #: (_____)_____ Home #: (_____)_____

Billing Address: _____
Street Address Suite #

_____
CITY STATE ZIP

Relation: _____ SS#: _____

Employer: _____

ORTHODONTIC INSURANCE

Primary

Orthodontic Coverage: ❑ Yes ❑ No Dental Coverage: ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address: _____
Street Address Suite #

_____
CITY STATE ZIP

Insurance Co. Phone #: (_____)_____

Group# (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Date of Birth: ____/_____/_____ Insured's ID #: _____

Insured's Employer: _____

Secondary

Orthodontic Coverage: ❑ Yes ❑ No Dental Coverage: ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address: _____
Street Address Suite #

_____
CITY STATE ZIP

Insurance Co. Phone #: (_____)_____

Group# (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Date of Birth: ____/_____/_____ Insured's ID #: _____

Insured's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

Name: _____ Relation: _____

Mobile #: (_____)_____ Work #: (_____)_____

Employer: _____

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MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: _____

Phone #: (_____)_____ Date of last visit: ____/_____/_____

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: _____

Are you taking any prescription/over-the-counter drugs? ❑ Yes ❑ No

Please list each one: _____

For Women: Are you using a prescribed method of birth control? ❑ Yes ❑ No

Are you pregnant? ❑ Yes (Week #: _____) ❑ No Are you nursing? ❑ Yes ❑ No

Have you ever had any of the following diseases or medical problems?

Abnormal Bleeding:	❑ Yes ❑ No	**Hemophilia**	❑ Yes ❑ No
Anemia:	❑ Yes ❑ No	**Hepatitis**	❑ Yes ❑ No
Artificial Bones/Joints/Valves:	❑ Yes ❑ No	**High/Low Blood Pressure**	❑ Yes ❑ No
Asthma/Arthritis:	❑ Yes ❑ No	**HIV+/AIDS**	❑ Yes ❑ No
Blood Transfusion:	❑ Yes ❑ No	**Hospitalized for Any Reason**	❑ Yes ❑ No
Cancer/Chemotherapy:	❑ Yes ❑ No	**Kidney Problems**	❑ Yes ❑ No
Congenital Heart Defect:	❑ Yes ❑ No	**Mitral Valve Prolapse**	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	**Psychiatric Problems**	❑ Yes ❑ No
Difficulty Breathing	❑ Yes ❑ No	**Radiation Treatment**	❑ Yes ❑ No
Drug/Alcohol Abuse	❑ Yes ❑ No	**Rheumatic/Scarlet Fever**	❑ Yes ❑ No
Emphysema	❑ Yes ❑ No	**Severe/Frequent Headaches**	❑ Yes ❑ No
Epilepsy/Seizures/Fainting	❑ Yes ❑ No	**Shingles**	❑ Yes ❑ No
Fever Blisters/Herpes	❑ Yes ❑ No	**Sickle Cell Disease/Traits**	❑ Yes ❑ No
Glaucoma	❑ Yes ❑ No	**Sinus Problems**	❑ Yes ❑ No
Heart Attack/Stroke	❑ Yes ❑ No	**Tuberculosis (TB)**	❑ Yes ❑ No
Heart Murmur	❑ Yes ❑ No	**Ulcers/Colitis**	❑ Yes ❑ No
Heart Surgery/Pacemaker	❑ Yes ❑ No	**Venereal Disease**	❑ Yes ❑ No

Please list any serious medical condition(s) that you have ever had:

_____

Are you allergic to any of the following?

Aspirin	❑ Yes	❑ No
Any Metals/Plastics	❑ Yes	❑ No
Codeine	❑ Yes	❑ No
Dental Anesthetics	❑ Yes	❑ No
Erythromycin	❑ Yes	❑ No
Latex	❑ Yes	❑ No
Penicillin	❑ Yes	❑ No
Tetracycline	❑ Yes	❑ No

Please list any other drugs/materials that you are allergic to:

_____

DENTAL HISTORY

What are the main concerns that you would like orthodontics to accomplish?

_____

Have you ever had or been evaluated for orthodontic treatment? ❑ Yes ❑ No

Have you ever had a serious/difficult problem associated with any previous dental work? ❑ Yes, please explain:_____ ❑ No

Do you now or have you ever experienced pain/discomfort in you jaw or joint (TMJ/TMD)? ❑ Yes ❑ No

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Do you like your smile? ❑ Yes ❑ No Gums ever bleed? ❑ Yes ❑ No

Have you ever had an injury to your: ❑ Mouth ❑ Teeth ❑ Chin

Do you have any speech problems? ❑ Yes ❑ No

Do you generally breathe through your mouth? ❑ Yes ❑ No

If yes, please circle: ❑ While Awake? ❑ While Asleep?

Do you have any missing or extra permanent teeth? ❑ Yes ❑ No

Do you smoke or use tobacco in any form? ❑ Yes ❑ No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

SIGNATURE DATE

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

_____

SIGNATURE DATE

I authorize payment of dental benefits in accordance with my current insurance policy to Precision Orthodontics, LLC for professional services rendered. I understand that I am responsible for the payment and also responsible for any co-payment and deductibles that my insurance does not cover.

_____

SIGNATURE DATE

I acknowledge that I have received a notice of Privacy Practices from Precision Orthodontics.

_____

SIGNATURE DATE

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

OFFICE USE ONLY

I verbally reviewed the medial/dental information above with the patient named herein.

Initials: _____ Date: ____/_____/_____

Doctors Comments: _____

_____

_____

_____