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& Associates

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Llorthodontics.com

Welcome

The benefits of a happy, healthy smile are immeasurable!
Our goal is to help you reach and maintain optimal oral health.
Please fill out this form completely. The better we communicate,
the better we can care for you.

About You

Today's Date:_____

Name:_____
Last First MI Mr Mrs Ms Dr

I prefer to be called:_____ ○ Male ○ Female

Birthdate:_____ Age:_____ SS#:_____

Home Address:_____
Apt/Condo #

_____
City State Zip

○ Single ○ Married ○ Divorced ○ Widowed ○ Separated

Hm#:_____ Cell _____

Wk#:_____ **Email:**_____

Employer:_____

Employer's Address:_____

_____
City State Zip

How long there?_____ Job Title:_____

Whom may we thank for referring you?_____

Other Family members seen by us:_____

General Dentist:_____

Last Visit Date:_____

We will confirm your appointments Via:

1) Text_____

2) Email_____

Spouse Information

His/Her Name_____

Employer_____

Wk#_____ Ext:_____ Cell:_____

Birthdate_____

SS#_____ Job Title:_____

Orthodontic Insurance

Primary

Person Responsable for Account_____

Orthodontic Coverage? ○ Yes ○ No Dental Coverage? ○ Yes ○ No

Insurance Co. Name:_____

Insurance Co. Phone #:_____

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

Insured's Name:_____ Relation:_____

Insured's Birthdate:_____

Insured's SS#:_____

Insured's Employer:_____

Employer's Address:_____

_____
City State Zip

Secondary

Orthodontic Coverage? ○ Yes ○ No Dental Coverage? ○ Yes ○ No

Insurance Co. Name:_____

Insurance Co. Phone #:_____

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

Insured's Name:_____ Relation:_____

Insured's Birthdate:_____

Insured's SS#:_____

Insured's Employer:_____

Employer's Address:_____

_____
City State Zip

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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:_____

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

Have you had any metal rods, pins, or implants? ○ Yes ○ No

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

Please list each one:_____

For Women: Are you taking birth control pills? ○ Yes ○ No

Are you pregnant? ○ Yes ○ No Week #:_____

Are you nursing? ○ Yes ○ No

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

○ Y ○ N	Abnormal Bleeding	○ Y ○ N	Hepatitis
○ Y ○ N	AIDS	○ Y ○ N	Herpes / Fever Blisters
○ Y ○ N	Alcohol / Drug Abuse	○ Y ○ N	High Blood Pressure
○ Y ○ N	Anemia	○ Y ○ N	HIV
○ Y ○ N	Arthritis	○ Y ○ N	Hospitalized for any Reason
○ Y ○ N	Artificial Bones / Joints / Valves	○ Y ○ N	Kidney Problems
○ Y ○ N	Asthma	○ Y ○ N	Liver Disease
○ Y ○ N	Blood Transfusion	○ Y ○ N	Low Blood Pressure
○ Y ○ N	Cancer / Chemotherapy	○ Y ○ N	Mitral Valve Prelapse
○ Y ○ N	Colitis	○ Y ○ N	Pacemaker
○ Y ○ N	Congenital Heart Defect	○ Y ○ N	Psychiatric Problems
○ Y ○ N	Diabetes	○ Y ○ N	Radiation Treatment
○ Y ○ N	Difficulty Breathing	○ Y ○ N	Rheumatic / Scarlet Fever
○ Y ○ N	Emphysema	○ Y ○ N	Seizures
○ Y ○ N	Epilepsy	○ Y ○ N	Shingles
○ Y ○ N	Fainting Spells	○ Y ○ N	Sickle Cell Disease / Traits
○ Y ○ N	Frequent Headaches	○ Y ○ N	Sinus Problems
○ Y ○ N	Glaucoma	○ Y ○ N	Stroke
○ Y ○ N	Hay Fever	○ Y ○ N	Thyroid Problems
○ Y ○ N	Heart Attack / Surgery	○ Y ○ N	Tuberculosis (TB)
○ Y ○ N	Heart Murmur	○ Y ○ N	Ulcers
○ Y ○ N	Hemophilia	○ Y ○ N	Venereal Disease

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

_____

_____

Are you allergic to any of the following?

○ Y ○ N	Aspirin	○ Y ○ N	Erythromycin	○ Y ○ N	Penicillin
○ Y ○ N	Codeine	○ Y ○ N	Jewelry/Metals	○ Y ○ N	Tetracycline
○ Y ○ N	Dental Anesthetics	○ Y ○ N	Latex	○ Y ○ N	Other

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

_____

OFFICE USE ONLY

I orally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Doctor's Comments:

_____

_____

_____

Initials: _____ Date: _____

Dental History

What are the main goals 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 ○ No

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

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

Do you still have your wisdom teeth? ○ Yes ○ No

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

Do you have any speech problems?_____

Do you generally breathe through your mouth? ○ Yes ○ No
If yes, please indicate: ☐ While Awake? ☐ While Asleep?

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

Are you happy with the way your smile looks? ○ Yes ○ No

If not, what would you change?

_____

Authorization

I certify that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and that 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:_____

HIPAA Acknowledgement

I give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews. I understand that I may review the practice's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent. I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice. I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction. I also understand that I may revoke this consent at any time by making a request in writing, except for information already used or disclosed.

Signature: _____

Patient, parent, or legal guardian

Date:_____

If signed by a patient representative, state relationship to patient:

_____