Date: _____

full smile ORTHODONTICS

Patient Name: _____ **DOB:** _____

Names of Legal Guardians (if applicable): _____

Male:_____ Female:_____ Age:_____

Mailing Address: _____ **City/State/:** _____ **Zip:** _____

Physical Address: _____ **City/State/:** _____ **Zip:** _____

ZIP:_____ E-mail:_____ Marital Status:_____

Home #:_____ Cell #:_____ SS#:_____

How did you hear about us? _____

Emergency Contact:_____ Phone #:_____

Insurance: Dental

Insurance Company:_____

Employer:_____

Insurance Address:_____

_____

Insurance Phone#:_____

Subscriber Name:_____

Subscriber DOB:_____ ID #:_____

SS #:_____ Group #: _____

Medical (Please Complete Thoroughly)

Insurance Company:_____

Employer:_____

Insurance Address:_____

_____

Insurance Phone#:_____

Subscriber Name:_____

Subscriber DOB:_____ ID #:_____

SS #:_____ Group #: _____

Guarantor (person responsible for paying): _____ Relationship to Guarantor: _____

Address:_____ City/State:_____

ZIP:_____ Home #:_____ SS #:_____

I AGREE TO PAY THE TOTAL AMOUNT DUE TO THE DOCTOR FOR SERVICES RENDERED AT MY REQUEST AND PERMIT THIS OFFICE TO SUBMIT INSURANCE CLAIMS ON MY BEHALF.

After you have finished completing this, please bring it up to the front desk along with a copy of your current Dental/Medical insurance cards, and a current Driver License.

Signature:_____

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED

IN OFFICE USE ONLY

- ☐ Copy of Dental Insurance Card
- ☐ Copy of Drivers License
- ☐ Copy of Medical Insurance Card
- ☐ Information Verified

Checked In Initials _____

Dental and Medical History

NAME OF YOUR GENERAL DENTIST?

DATE OF LAST DENTAL VISIT?

FOR WHAT SERVICE?

ANY INJURIES TO MOUTH, TEETH, OR HEAD?

HAVE YOU HAD AN UNHAPPY DENTAL EXPERIENCE?

GENERAL PHYSICIAN

PHONE # | DATE OF LAST VISIT

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN?

◯ YES ◯ NO

DESCRIBE YOUR CURRENT PHYSICAL HEALTH:

◯ GOOD ◯ FAIR ◯ POOR

PLEASE LIST ALL DRUGS AND FOODS THAT YOU ARE ALLERGIC TO AND TYPE OF REACTION

PLEASE LIST ALL MEDICATIONS/SUPPLEMENTS THAT YOU ARE CURRENTLY TAKING:

DO YOU HAVE ANY OF THE FOLLOWING HABITS?

YES	NO	
◯	◯	THUMB / FINGER SUCKING
◯	◯	LIP SUCKING / BITING
◯	◯	NAIL BITING
◯	◯	MOUTH BREATHING
◯	◯	NIGHTTIME GRINDING OF TEETH

DO YOU HAVE A HEART CONDITION? (SUCH AS A HEART MURMUR)

◯ YES ◯ NO

IF YES, EXPLAIN

CARDIOLOGIST'S NAME

PHONE#

Health History

DO YOU HAVE ANY OF THE FOLLOWING MEDICAL PROBLEMS?

YES	NO	
◯	◯	CANCER / TUMORS
◯	◯	DIABETES
◯	◯	RHEUMATIC FEVER
◯	◯	HIV+ / AIDS
◯	◯	HEMOPHILIA
◯	◯	ASTHMA
◯	◯	HEPATITIS
◯	◯	TUBERCULOSIS (TB)
◯	◯	CHRONIC UPPER / RESPIRATORY PROBLEMS
◯	◯	CONVULSION / EPILEPSY
◯	◯	ABNORMAL BLEEDING
◯	◯	HEARING IMPAIRMENT
◯	◯	VISION PROBLEMS
◯	◯	ANY OPERATIONS '(PLEASE EXPLAIN BELOW)
◯	◯	ANY HOSPITAL STAYS '(PLEASE EXPLAIN BELOW)
◯	◯	KIDNEY / LIVER PROBLEMS
◯	◯	HANDICAPS / DISABILITIES
◯	◯	ALLERGIES
◯	◯	PEANUT ALLERGY
◯	◯	PREGNANT
◯	◯	SMOKER
◯	◯	ADD&ADHD
◯	◯	DEVELOPMENTALLY DELAYED
◯	◯	AUTISM
◯	◯	DOWNS SYNDROME
◯	◯	SPEECH PROBLEMS

PLEASE DISCUSS ANY SERIOUS MEDICAL PROBLEMS THAT YOU HAVE/HAD:

I UNDERSTAND THAT THE INFORMATION THAT I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE, THAT IT WILL BE HELD IN THE STRICTEST OF CONFIDENCE, AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS. I ALSO AUTHORIZE THE DOCTORS AND THE DENTAL STAFF TO PERFORM ANY NECESSARY DENTAL SERVICES I MAY NEED.

SIGNATURE

X

DATE

Thank you for letting us be an important part of your dental health.