CAVERN CITY ORTHODONTICS

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ADA | DIPLOMATE AMERICAN BOARD OF ORTHODONTICS | Member American Association of Orthodontists

## 1 About You

Today's Date: _____ E-Mail Address: _____

**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 #: (____)_____ Pager / Other #: _____

Wk #: (____)_____ Ext: ____ DL #: _____

**Employer:** _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & 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: _____

## 2 Spouse Information

His / Her Name: _____

Employer: _____

Wk #: (____)_____ Ext: ____ SS #: _____

Birthdate: ___/___/___

**Person Responsible for Account:** _____

Wk #: (____)_____ Ext: ___ Hm #: (____) _____

Billing Address: _____

Relation: _____ SS #: _____

Employer: _____ DL #: _____

## 3 Orthodontic Insurance

### Primary

Orthodontic Coverage: ☐ Yes ☐ No Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

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

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's SS #: _____

Insured's Employer: _____

### Secondary

Orthodontic Coverage: ☐ Yes ☐ No Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

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

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's SS #: _____

Insured's Employer: _____

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

His / Her Name: _____ Relation: _____

Wk #: (____)_____ Hm #: (____) _____

## 4 Medical History

**Do you have a personal physician?** ☐ Yes ☐ No

Physician's Name: _____

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

**CONTINUED ON BACK**

## 4 MEDICAL HISTORY *continued*

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 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 | Hemophilia |
| Y | N | Anemia | Y | N | Hepatitis |
| Y | N | Artificial Bones / Joints / Valves | Y | N | High / Low Blood Pressure |
| Y | N | Asthma /Arthritis | Y | N | HIV+ / AIDS |
| Y | N | Blood Transfusion | Y | N | Hospitalized for Any Reason |
| Y | N | Cancer / Chemotherapy | Y | N | Kidney Problems |
| Y | N | Congenital Heart Defect | Y | N | Mitral Valve Prolapse |
| Y | N | Diabetes | Y | N | Psychiatric Problems |
| Y | N | Difficulty Breathing | Y | N | Radiation Treatment |
| Y | N | Drug / Alcohol Abuse | Y | N | Rheumatic / Scarlet Fever |
| Y | N | Emphysema | Y | N | Severe / Frequent Headaches |
| Y | N | Epilepsy / Seizures / Fainting | Y | N | Shingles |
| Y | N | Fever Blisters / Herpes | Y | N | Sickle Cell Disease / Traits |
| Y | N | Glaucoma | Y | N | Sinus Problems |
| Y | N | Heart Attack / Stroke | Y | N | Tuberculosis (TB) |
| Y | N | Heart Murmur | Y | N | Ulcers / Colitis |
| Y | N | Heart Surgery / Pacemaker | 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 | Dental Anesthetics | Y | N | Penicillin |
| Y | N | Any Metals/Plastics | Y | N | Erythromycin | Y | N | Tetracycline |
| Y | N | Codeine | Y | N | Latex | Y | N | Other |

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

_____

## 5 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 ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw 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 (Please Circle)

Do you have any speech problems? _____

Do you generally breathe through your mouth? ☐ es ☐ No

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

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

Have you ever taken Phen-Fen? (Also known as Redux or Pondimin) ☐ Yes ☐ No

If yes, when? _____

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

## I

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**

## Thank you for filling out this form completely.

**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**

**If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.**

_____

**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 OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

**I verbally reviewed the medical / dental information above with the patient named herein. Initials:** _____ **Date:** _____

**Doctor's Comments:** _____

_____

_____

_____

_____