WELCOME TO THE ORTHODONTIST

CONFIDENTIAL

1. ABOUT YOU

Today's Date: ____________________
Title : MR ☐ MRS. ☐ DR ☐ MS. ☐
Name:____
Last First MI
I prefer to be called: _____________ Male ☐ Female ☐
Birth Date: __________ Age: ______ SSN #____________
Home Address:_____________________________________
____
City __________________ State ________ Zip_______
Single Widowed Separated Married Divorced
Home# : ____
Work# : ____
Employer : ____
Employer Address : _______________________________
How long there : __________________________________
Occupation : ______________________________________
Whom may we Thank for referring you? : ___________
General Dentist : __________________________________
Last Visit Date : __________________________________

2. SPOUSE INFORMATION

His or Her Name: ________________________________
Employer: _______________________________________
Work#: ___________________________ext: __________
SS#: _____________________________________
Birthday: _____/_____/_____

Person Responsible for Account: _________________
Work#: ___________________________ext: _________
Home#: ________________________________
Billing Address: ________________________________
____
City ______________ State ________ Zip __________
Relation:________________SSN#: _____________
Employer: ______________________________
DL#: __________________________________

3. ORTHODONTIC INSURANCE

Primary

Orthodontic Coverage? Yes ☐ No ☐
Insurance Co. Name: ______________________________
Insurance Co. Address: ____________________________
Insurance Co. Phone #: ____________________________
Group#: ____
SSN#: ____
Policy Owner's Name: ______________________________
Relationship to Patient:____________________________
Policy Owner's Birthday: ___________________________
Policy Owner's Employer: ___________________________

Secondary

Orthodontic Coverage? Yes ☐ No ☐
Insurance Co. Name: ______________________________
Insurance Co. Address: ____________________________
Insurance Co. Phone #: ____________________________
Group#: ____
SSN#: ____
Policy Owner's Name: ______________________________
Relationship to Patient:____________________________
Policy Owner's Birthday: ___________________________
Policy Owner's Employer: ___________________________

In the event of emergency, is there someone who lives near you that we should contact?
His/ Her name: _________________________________
Relation: ______________________________________
Work#: _______________ Home#: _______________

4. MEDICAL HISTORY

Do you have 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 physician? Y N
Are you taking any prescriptions / over the counter drugs Y N
Please list each one: ______________________________
For Woman: Are you taking Birth Control Pills Y N
Are you pregnant Y N
Week number: ______________________________
Are you nursing Y N

Have you ever have the following:
Y N Anemia/Radiation Treatment
Y N Artificial bones / joints
Y N Artificial valves
Y N Blood Transfusion
Y N Cancer/ Chemotherapy
Y N Congenital Heart Defect
Y N Diabetes/ Tuberculosis (TB)
Y N Difficulty Breathing
Y N Drugs/ Alcohol abuse
Y N Emphysema/Glaucoma
Y N Epilepsy/Seizure/Fainting/Spell
Y N Fever Blister/ Herpes
Y N Heart Attack / Stroke
Y N Heart Murmur
Y N Heart Surgery / Pacemaker
Y N Hemophilia / Abnormal bleeding
Y N Hepatitis
Y N High / Low Blood pressure
Y N HIV +/ AIDS
Y N Hospitalized of any reason
Y N Kidney Problem
Y N Mitral valve prolapse
Y N Psychiatric problem
Y N Rheumatic / Scarlet fever
Y N Severe/ frequent headache
Y N Shingles
Y N Sinus Problem
Y N Ulcer Colitis
Y N Venereal Disease
Please list any serious medical condition (s) that you have ever had : ______________________________
____
____

Are you allergic to any following?

Y N Aspirin
Y N Penicillin
Y N Tetracycline
Y N Latex
Y N Dental Anesthetics
Y N Any Metal / Plastic
Y N Codeine
Y N Other

5. DENTAL HISTORY

What are the main concern that you would like orthodontics to accomplish?
____
____
____
Have you ever had or been evaluated for orthodontic treatment? Y N
Have you ever had serious / difficult problem associated with any previous dental work? Y N
Do you now or have you experience pain / discomfort in your jaw joint (TMJ/TMD) ? Y N
Your current dental health is: Good Fair Poor
Do you like to smile? Y N
Did your gum ever bleed? Y N
Have you ever had a injury to your :(please circle)
Mouth Teeth Chin
Do you have speech problem: ______________________________
____
Do you generally breath through your mouth? Y N
Awake? Y N Asleep? Y N
(please circle)
Do you have permanent missing teeth?
Y N

I understand that the information that I have given today 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 child's medical status. I authorize the dental staff to perform the necessary dental service I may need during diagnosis and treatment with my informed consent.

____
Signature Date

I authorize my insurance company to pay Dr. Emeline Abay all insurance benefit otherwise payable to me for service rendered. I authorized to use of this signature on all insurance form. I authorized Dr. Emeline Abay to release all information necessary to secure the payment of benefits. I understand I am financially responsible for all charges whether or not paid by insurance.

Signature ______________________________ Date: ______________

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

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

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

Doctor's Comments: Initials: ____________ Date: ________________
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