Welcome TO SOUTHEAST ORTHODONTICS

A beautiful smile is a wonderful asset. Please fill out this form completely. The better we communicate, the better we can care for you.

Today's Date: _____

1 About You

Name: _____ ☐ M ☐ F
LAST FIRST MI

Birthdate: ____/____/____ Age: _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Address: _____

_____

Hm #: (_____)_____ Cell #: (_____)_____

Wk #: (_____)_____ DL #: _____

E-Mail Address: _____

Employer: _____

Employer's Address: _____

_____

How long there?_____ Occupation: _____

☐ Emergency Contact is: _____

_____

2 Responsible Party Information

☐ Patient - See Above ☐ Other - Complete Below

Name:_____ Relation: _____

Birthdate: ____/____/____ DL #:_____

Billing Address: _____

_____

Hm #: (_____)_____ Cell #: (_____)_____

Employer:_____ Wk #: (_____)_____

Email: _____

3 Family / Referral Information

List other family members seen by us: _____

_____

Whom may we thank for referring you? _____

4 Primary Insurance Information

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (_____) _____

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

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____ ID #: _____

Policy Owner's Employer: _____

Employer's Address: _____

_____

Secondary Insurance Information

Insurance Co. Name:_____

Insurance Co. Address: _____

_____

Insurance Co. Phone #: (_____)_____

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

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____ ID #: _____

Policy Owner's Employer: _____

Employer's Address: _____

_____

_____

5 Dentist Information

General Dentist: _____

Date of last cleaning: ____/____/____

Continued on back

6 Medical History

Your Physician: _____

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

Are you under the care of a physician? ☐ Y ☐ N

(Women) Are you using prescribed birth control? ☐ Y ☐ N

(Women) Are you pregnant? ☐ Y ☐ N

(Women) Are you nursing? ☐ Y ☐ N

Please describe your current physical health:

Good ☐ Fair ☐ Poor ☐

Have you ever had any of the following problems? (Please Circle)

Y N	Abnormal Bleeding	Y N	Handicaps / Disabilities
Y N	ADD / ADHD	Y N	Hearing Impairment
Y N	Asperger's Syndrome/ Autism	Y N	Heart Murmur
Y N	Artificial Bones / Joints	Y N	Hemophilia
Y N	Artificial Valves	Y N	Hepatitis
Y N	Asthma	Y N	HIV+ / AIDS
Y N	Cancer	Y N	Kidney / Liver Problems
Y N	Congenital Heart Defect	Y N	Lupus
Y N	Convulsions / Epilepsy	Y N	Rheumatic / Scarlet Fever
Y N	Diabetes	Y N	Tuberculosis (TB)

Please list all drugs that you are currently taking:

_____

Please list any serious medical conditions, hospital stays or operations that you have ever had:

_____

Are you allergic to any of the following? (Please Circle)

Y N Metals / Plastics Y N Latex Y N Other

Please list any other drug / material allergies:

_____

_____

7 Dental History

What would you like orthodontics to accomplish?

_____

Have you ever been evaluated or had orthodontic treatment before? ☐ Y ☐ N

Have you had any injuries to the face, mouth, teeth or chin? ☐ Y ☐ N

List any musical instruments played: _____

_____

Have adenoids or tonsils been removed? ☐ Y ☐ N

Have you been informed of any missing or extra permanent teeth? ☐ Y ☐ N

Have you ever had any pain / tenderness in your jaw joint (TMJ / TMD)? ☐ Y ☐ N

Have you ever experienced any of the following? (Please Circle)

Y N	Clenching / Grinding Teeth	Y N	Nursing / Bottle Habits
Y N	Lip Sucking / Biting	Y N	Speech Problems
Y N	Mouth Breather	Y N	Thumb / Finger Sucking
Y N	Nail Biting	Y N	Tongue Thrust

Have you been evaluated for sleep apnea or trouble sleeping or snoring? ☐ Y ☐ N

Do you brush your teeth daily? ☐ Y ☐ N

Do you floss your teeth daily? ☐ Y ☐ N

8 Signed Consents

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 OF RESPONSIBLE PERSON 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 deductible's that my insurance does not cover. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office.

_____

SIGNATURE OF RESPONSIBLE PERSON DATE

TFD 8330

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 medical / dental information above with the patient named herein. Initials: _____ Dates: _____

Doctor's Comments: _____

_____