WELCOME!

We would like to welcome you to our office. Our goal is to help you achieve a beautiful smile while reaching and maintaining maximum oral health in a warm, courteous, safe and caring environment. Please fill out these forms completely.

Tell Us About Yourself

Today's Date:________

Name:_____ Birthdate:_____

Home Phone#:_____Cell Phone #_____

Cell Phone Provider:_____Email_____

Home Address:_____

_____

City State Zip Code

How may we best contact you? _____

Employer:_____Work #_____

Occupation:_____

Spouse/Significant other's name:_____

Emergency Contact Name:_____

Emergency Contact Phone #:_____

Other family members seen by us:_____

Dentist_____Physician_____

Whom may we thank for referring you?_____

Medical History

Have you ever had the following medical problems?

Y	N	Latex Sensitive	Y	N	Allergies to drugs, substances
Y	N	Allergies	Y	N	Fainting or Dizzy Spells
Y	N	Heart Murmur	Y	N	Congenital Heart Defect
Y	N	Cancer	Y	N	Convulsions/Epilepsy
Y	N	Diabetes	Y	N	Abnormal Bleeding
Y	N	Rheumatic Fever	Y	N	Hearing Impairment
Y	N	HIV+/AIDS	Y	N	Any Operations
Y	N	Hemophilia	Y	N	Any stays in a hospital
Y	N	Asthma, Airway or Breathing Problems	Y	N	Kidney/Liver Problems
Y	N	Hepatitis	Y	N	Handicaps/Disabilities
Y	N	TB/Lung Disorders	Y	N	Cold Sores/Fever Blisters
Y	N	Blood Transfusion	Y	N	Veneral Disease
Y	N	Mitral Valve Prolapse	Y	N	Diet (special, restricted)
Y	N	Sickle Cell Disease	Y	N	Artificial Joints (hip,etc.)
Y	N	Ulcers/Stomach Disorders	Y	N	Thyroid Problems
Y	N	Chemotherapy, Radiation Treatment	Y	N	Tumors
Y	N	Nervous/Anxious	Y	N	ADD, ADHD, PDD (circle one)
Y	N	Austism, Asperger's Syndrome (circle one)	Y	N	Psychiatric/Psychological Problems
Y	N	Heart Attack/Stroke	Y	N	Pacemaker
Y	N	Glaucoma	Y	N	Emphysema
Y	N	High /Low Blood Pressure (circle one)	Y	N	Severe or frequent headaches
Y	N	Osteoporosis/Osteopenia			

Please explain any medical problems that you may have:_____

_____

Are you currently under the care of a physician? Y N If yes, for what condition?_____
Have you been a hospital patient during the past two years? Y N

Women: Are you pregnant? Y N Week #_____
Nursing? Y N
Taking birth control pills? Y N

Please list all drugs that you are is currently taking and the condition they are addressing:_____

_____

Have you ever been treated with medications for osteoporosis, osteopenia, abnormal bone conditions or cancer?
If yes, please list name of medication(s) :(i.e., Fosamax, Actonel, Zometa, Aredia, Boneva, etc.)

_____

Please list all drugs/substances that you are allergic to:_____

_____

Dental History

Have you had any previous orthodontic consultations or had orthodontic treatment? Y N
Why did you come to the orthodontist today?_____

_____

Date of last dental visit?_____ Full x-rays_____

Have you ever had serious/difficult problems associated with previous dental work? Y N

Have you ever had?

Y N Oral Surgery
Y N Serious Injury (mouth/head)
Y N Periodontal treatment
If yes, please describe:_____

Have you ever experienced?

Y N	Difficulty in chewing	Y N	Tired Jaws
Y N	Pain (joint, ear, face)	Y N	Problem opening, closing mouth
Y N	Headaches	Y N	Clicking or popping of jaw

Do you frequently get cold sores, blisters or any other oral lesions? Y N
Your current dental health is: Good Fair Poor
Do you grind your teeth? Y N
Do your gums ever bleed? Y N
Do you like your smile? Y N

I understand the above information is necessary to provide me with orthodontic care in a safe, caring, confidential and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

It is important that you attend your appointments. Please understand that a last minute cancellation or "no show" does not allow us enough time to accommodate another patient. Because the time we allot for you is valuable, kindly give our office 24 hours' notice if you must cancel your appointment. We reserve the right to charge a $150.00 for every 30 minutes of any appointment not cancelled within 24 hours.

As a courtesy and service to our patients we will provide a "super bill" that you may submit with your claim form for reimbursement from your insurance company. We do not accept assignment of benefits from the insurance companies. I understand that I am responsible for all costs of orthodontic treatment.

Signature of Responsible Party

_____Date_____

Please initial to acknowledge that you have received the Notice of Privacy Practices_____