JAMES WATERS ORTHODONTIST

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Austin, TX 78703
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## 1 About You

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

**Name:** kk ash
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: 2011-11-17 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: 2011-11-17 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: 2011-11-17 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: 2011-11-17

**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 (Check all that apply)

Do you have any speech problems?

Do you generally breathe through your mouth? ☐ Yes ☐ No
If yes, please check: ☐ 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:** _____