JAMES WATERS ORTHODONTIST

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1 About You

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

Name: shei
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: 2011-10-21 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 (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: _____