JAMES WATERS ORTHODONTIST

Bastrop
708 Pecan
Bastrop, TX 78602
(512) 303-1060

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Steiner Ranch Orthodontics
4302 N Quinlan Park Rd.
Austin, TX 78732
(512) 266-8585

Central Austin
1814 W. 35th Street
Austin, TX 78703
(512) 451-6457

ADA® DIPLOMATE AMERICAN BOARD OF ORTHODONTICS Member American Association of Orthodontists

1 About You

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

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: ___/___/___ 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.

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I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ **Date:** _____

Doctor's Comments: _____