Peterson Orthodontics

1. ABOUT YOU

Today's Date:_____

Name:_____
Last First M. Ini.

I prefer to be called:_____ ❑ Male ❑ Female

Birthdate: _____/_____/_____ Age:_____

SS#:_____

Home Address:_____

_____
City State Zip

❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ 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:_____

Any Treatment Rendered?_____

E-Mail_____

2. SPOUSE INFORMATION

His/Her Name:_____

Employer:_____

Wk#:( ) _____ Ext._____

SS#:_____

Birthdate:_____/_____/_____ Age:_____

Person Responsible for Account:_____

Wk#:( ) _____ Ext._____ Hm#:( )_____

Billing Address:_____

Relation:_____ SS#:_____

3. ORTHODONTIC INSURANCE

Orthodontic Coverage? ❑Yes ❑ No

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone#: ( )_____

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

Insured's Name:_____

Relationship to Patient:_____

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 #: ( )_____

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 #:_____

4. MEDICAL HISTORY *continued*

Have you ever had any of the following diseases or medical problems?

Y N Anemia/Radiation Treatment
Y N Artificial Bones/Joints
Y N Artificial Valves
Y N Asthma Arthritis
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Congenital Heart Defect
Y N Diabetes/Tuberculosis
Y N Difficulty Breathing
Y N Drug/Alcohol Abuse
Y N Emphysema/Glaucoma
Y N Epilepsy/Seizure/Fainting Spells
Y N Fever Blisters/Herpes
Y N Heart Attach/Stroke
Y N Heart Murmur
Y N Heart Surgery/ Pacemaker
Y N Hemophilia/Abnormal Bleeding
Y N Hepatitis
Y N High/Low Blood Pressure
Y N HIV +/AIDS
Y N Hospitalized for Any Reason
Y N Kidney Problems
Y N Mitral Valve Prolapse
Y N Psychiatric Problems
Y N Rheumatic/Scarlet Fever
Y N Severe/Frequent Headaches
Y N Shingles
Y N Sinus Problems
Y N Ulcers/Colitis
Y N Veneral 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 Codeine Y N Any Metal/Plastic Y N Latex

5. DENTAL HISTORY

What are the main concerns that you would like orthodontics to accomplish?

_____
_____
_____

Have you ever 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

Do your gums bleed? ❑ Yes ❑ No

Have you ever had an injury to your: Mouth Teeth Chin

Do you have any speech problems?

_____

Do you generally breathe through your mouth?
Y N Awake? Y N Asleep?

Do you have any missing or extra permanent teeth?
❑ Yes ❑ No

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. I authorize the orthodontist to provide my health care information to my other health providers, and /or to receive health care information from them relevant to my treatment.

Our office will bill your insurance as a courtesy to you. Insurance benefits are a contract between you and your insurance company. You are responsible for all charges due on this account.

_____
Signature Date

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDA and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally retrieved the medical / dental information above with the patient named herein.

Doctor's Comments Initials: _____ Date: _____

_____

_____