WELCOME TO Dr. J's

The benefits of a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset!
Please fill out the form completely. The better we communicate, the better we can care for you!

1. About you:

Today's date: _____
Name: _____
LAST FIRST MI
Nickname: _____
Birthdate: ___/___/___ Age: ___
☐Male ☐Female
Home address: _____
_____
Hm# (____)____-_____
Wk# (____)____-_____
Cell# (____)____-_____
Home email: _____
Work email: _____
SSN#_____ DL#_____
☐ Single ☐ Married ☐ Divorced ___
☐ Widowed ☐ Separated
Employer: _____
Employer Address: _____
_____
How long there?_____ Occupation: _____
When is the best time to reach you? _____
Whom may we thank for referring you? _____
_____
Other family members seen by us? _____
General Dentist: _____
Last visit: _____

2. Spouse Information

His/Her Name: _____
Employer: _____
Wk# (____) ____-_____
SSN# _____
Birthdate: _____

Person Responsible for Account: _____
Hm# (___) ___-____Wk# (____)___-____
Billing Address: _____
_____
Relation to Patient: _____
SSN#_____ DL#_____
Employer: _____
How long at current job: _____

Emergency contact: Name: _____
Phone Number: (____) ____-_____

3. Primary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No
Insurance Company Name: _____
Insurance Company Ph# (____) ____-_____
Policy Holder Name: _____
Relation to Patient: _____
Policy holder Birthdate: ____/____/____
Employer: _____ Group# _____
Subscriber ID# _____
Subscriber SSN# _____
Insurance Company Address: _____
_____

Secondary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No
Insurance Company Name: _____
Insurance Company Ph# (____) ____-_____
Policy Holder Name: _____
Relation to Patient: _____
Policy holder birthdate: ____/____/____
Employer: _____ Group# _____
Subscriber ID# _____
Subscriber SSN# _____
Insurance Company Address: _____
_____

4. Medical History

Do you have a physician? Yes☐No☐
Physician's name: _____
Ph# (____) _____ Date of last visit: _____
Your current physical health is:☐Good☐Fair☐Poor
Are you currently under the care of this physician?
☐ Yes ☐ No If so, please explain: _____
_____
Are you taking any prescription or over-the-counter medications? ☐ Yes ☐ No
Please list each one: _____
_____
For women: Are you currently taking birth control pills? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No Week #_____
Are you nursing? ☐ Yes ☐ No

CONTINUED ON BACK

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

Have you ever taken any of the following?
☐ Fen-Phen ☐ Redux ☐ Pondimin
If so, when? _____

Have you ever taken any of the following?
☐ Zometa ☐ Aredia ☐ Boniva ☐ Actonel ☐ Fosamax
If so, when? _____

Have you ever been evaluated for orthodontic treatment before? ☐ Yes/No ☐
Have you ever had a serious or difficult problem associated with previous dental work? ☐ Yes/No ☐
Have you ever had any injuries to face, mouth or chin? ☐ Yes/No ☐
Have you been informed you are missing or have extra permanent teeth? ☐ Yes/No ☐

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes/No ☐
Do your gums ever bleed? ☐ Yes/No ☐
Do you now or have you ever had any pain or tenderness in your jaw joint (TMJ)? ☐ Yes/No ☐
Do you brush your teeth daily? ☐ Yes/No ☐
Do you floss daily? ☐ Yes/No ☐

Do you generally breathe through your mouth? ☐ Yes/No ☐
If yes, please circle: ☐ While awake ☐ While asleep

Have you ever exhibited any of the following?

☐Y ☐N Clenching/Grinding of teeth ☐Y ☐N Tongue Thrust
☐Y ☐N Nail biting
☐Y ☐N Lip sucking/biting ☐Y ☐N Speech Problem

6. Have you ever been diagnosed with any of the following diseases or medical conditions?

☐Y ☐N Abnormal bleeding
☐Y ☐N Anemia
☐Y ☐N Artificial Bones/ Joints/Valves
☐Y ☐N Asthma/Difficulty Breathing
☐Y ☐N Arthritis
☐Y ☐N Blood Transfusion
☐Y ☐N Cancer/Chemotherapy
☐Y ☐N Congenital Heart Defect
☐Y ☐N Diabetes
☐Y ☐N Drug/Alcohol Abuse
☐Y ☐N Emphysema
☐Y ☐N Epilepsy/Seizures
☐Y ☐N Fainting
☐Y ☐N Fever Blisters/Herpes
☐Y ☐N Glaucoma
☐Y ☐N Heart Attack/Stroke
☐Y ☐N Heart Murmur
☐Y ☐N Heart Surgery/ Pacemaker
☐Y ☐N Hemophilia
☐Y ☐N Hepatitis A/B/C
☐Y ☐N High/Low Blood Pressure
☐Y ☐N HIV/AIDS
☐Y ☐N Hospitalization
☐Y ☐N Kidney problems
☐Y ☐N Mitral Valve Prolapse
☐Y ☐N Psychiatric problems
☐Y ☐N Radiation Therapy
☐Y ☐N Rheumatic/ Scarlet Fever
☐Y ☐N Severe or Frequent Headaches
☐Y ☐N Shingles
☐Y ☐N Sickle Cell Disease
☐Y ☐N Sinus Problems
☐Y ☐N Tuberculosis
☐Y ☐N Ulcers/Colitis

Please provide additional information regarding any of the above listed conditions or any other medical problems:
_____

7. Are you allergic to any of the following?

☐Y ☐N Aspirin
☐Y ☐N Codeine
☐Y ☐N Dental Anesthetics
☐Y ☐N Erythromycin
☐Y ☐N Latex
☐Y ☐N Metals
☐Y ☐N Penicillin
☐Y ☐N Plastics
☐Y ☐N Tetracycline
☐Y ☐N Others

Please list others: _____

8. I understand that the information I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

_____

*This office will not be held responsible for any problems arising from information not disclosed.

9. I authorize the Orthodontist to share my treatment information with collaborating dentists and surgeons when appropriate. I authorize the Orthodontist to submit pertinent treatment information to the insurance company for billing purposes only.

_____
Signature Date

FOR OFFICE USE ONLY

I have verbally reviewed the medical/dental information provided with parent/guardian and patient name herein.

_____
Orthodontist Signature Date

OFFICE USE ONLY
UPDATES

I have reviewed information originally provided and made appropriate changes:
___Initials_____Date ___Initials_____Date
___Initials_____Date ___Initials_____Date

Submit Form