SMILE ART ORTHODONTICS

New Patient Information

Please assist us in your/your child's treatment by filling this form out accurately and completely. Thank you!

Patient information

Patient's Name (Last, First, MI): _____ Prefers to be called: _____

Birth date: _____ Age: _____ Gender: ☐ Male ☐ Female

Home address: _____

Tel #: Home: _____ Work: _____ Cell: _____

Which to use as primary contact #? _____ Who to contact for scheduling/confirming?: _____

For adult patients: Email: _____ Occupation: _____

For minor patients: School: _____ Grade: _____

Hobbies / Sports / Musical inst.: _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Responsible Party Information #1

If patient is under 18, please complete the Responsible Party Information section/s. Also, if patient is over 18, but would like to add a parent/spouse or other responsible party, please complete this section.

Name (Last, First, MI): _____

Relationship to patient: _____ Birth date: _____ Gender: ☐ Male ☐ Female

Address (if different from patient): _____

Tel #: Home (if different): _____ Work: _____ Cell: _____

Email: _____ Occupation: _____

If married, spouse's name: _____

Responsible Party information #2

If patient is under 18, please complete this section with information for second parent/responsible party. Skip if not applicable.

Name (Last, First, MI): _____

Relationship to patient: _____ Birth date: _____ Gender: ☐ Male ☐ Female

Address (if different from patient): _____

Tel #: Home (if different): _____ Work: _____ Cell: _____

Email: _____ Occupation: _____

If married, spouse's name: _____

Emergency Contact Information

Please fill this section if you are an adult patient and have skipped both the Responsible Party information sections above.

Name (Last, First, MI): _____ Relationship to patient: _____

Address: _____

Tel #: Home: _____ Work: _____ Cell: _____

Patient's Medical History

Physician's Name: _____ Approximate Date of last visit: _____

Physician's address (City & State): _____ Phone #: _____

Currently seeing physician for anything other than routine care? ☐ Yes ☐ No

If yes, please explain: _____

Taking any prescription/over-the-counter drugs? ☐ Yes ☐ No

If yes, please specify and explain reason: _____

_____

History of any major illness/hospitalization? ☐ Yes ☐ No

If yes, please explain: _____

List allergies or sensitivity to medications if any: _____

List allergies to foods/nuts if any: _____

Latex allergy? ☐ Yes ☐ No

Use any tobacco products? ☐ Yes ☐ No If yes, what and how often? _____

For Minor Girl patients: Post-menarchial? ☐ Yes ☐ No If yes, approximate date of menarche: _____

For Women patients: Are you pregnant or nursing? ☐ Yes ☐ No Are you on birth control pills? ☐ Yes ☐ No

Please check any of the following that patient has had/been treated for/currently has. Select all that apply:

☐ Abnormal bleeding/Hemophilia	☐ Cold sores/fever blisters/Oral Herpes	☐ Heart attack/stroke
☐ ADD/ADHD	☐ Congenital heart defect	☐ Heart murmur
☐ Anemia	☐ Diabetes	☐ Hepatitis
☐ Arthritis	☐ Difficulty breathing	☐ High blood pressure
☐ Artificial joints/heart valves	☐ Drug/Alcohol abuse	☐ HIV+/AIDS
☐ Asthma or Hay Fever	☐ Eating disorder	☐ Osteoporosis
☐ Auto-immune disease	☐ Emphysema	☐ Psychiatric conditions
☐ Blood disorders	☐ Epilepsy/seizures/convulsions	☐ Radiation/Chemotherapy
☐ Cancer	☐ Fainting/Dizziness	☐ Rheumatic fever
☐ Canker sores/oral apthous ulcers	☐ Hearing loss/impairment	☐ Tuberculosis

Please list details of any conditions if checked above and also any medical conditions not listed above that you feel we should be aware of: _____

_____

_____

Patient's Dental History

General dentist's name: _____ Approximate date of last visit: _____

General Dentist's address (City & State): _____

Currently seeing/have seen a Periodontist? ☐ Yes ☐ No If Yes, list Name: _____

Reason for Periodontal care: _____

What is the chief concern that brings you to the orthodontist? _____

_____

_____

Please check any of the following which apply to patient, and add any relevant details below:

Ever had or been evaluated for orthodontic treatment?			☐ Yes	☐ No
Ever experienced any unfavorable reaction to dentistry?			☐ Yes	☐ No
Lost or chipped any teeth?			☐ Yes	☐ No
Have there been any injuries to face, mouth or teeth?	☐ Mouth	☐ Teeth	☐ Chin	☐ Face
Bleeding gums?			☐ Yes	☐ No
Any speech problems?			☐ Yes	☐ No
Mouth breather?			☐ Yes	☐ No
If yes, please select applicable:	☐ While awake	☐ While asleep		
Thumb/finger sucking habit?			☐ Yes	☐ No
Tongue thrust habit?			☐ Yes	☐ No
History of clenching/grinding teeth?			☐ Yes	☐ No
Hx of "TMJ" pain/problems/treatment?			☐ Yes	☐ No
Missing/extra permanent teeth?			☐ Yes	☐ No

Please give details for any responses checked as "Yes" above: _____

_____

_____

_____

Any other information you would like to share with us that may be relevant to the orthodontic treatment?

_____

_____

_____

FINANCIAL / INSURANCE INFORMATION

Who is financially responsible for the account? _____

Please take care in filling out the required insurance information accurately in order to facilitate efficient billing and claims processing. If you have an insurance card, please bring it with you for the first visit. Thanks!

Primary Insurance

Orthodontic Coverage: ☐ Yes ☐ No ☐ Don't know Dental Coverage: ☐ Yes ☐ No ☐ Don't know

Subscriber's name: _____ Subscriber's birthdate: _____

Subscriber's Employer: _____ Group #: _____

Insurance co. name: _____

Insurance co. phone #: _____

Subscriber's SS#: _____ ID# / Policy#: _____

Secondary Insurance

If patient has dual insurance coverage, please complete Secondary Insurance information below.

Orthodontic Coverage: ☐ Yes ☐ No ☐ Don't know Dental Coverage: ☐ Yes ☐ No ☐ Don't know

Subscriber's name: _____ Subscriber's birthdate: _____

Subscriber's Employer: _____ Group #: _____

Insurance co. name: _____

Insurance co. phone #: _____

Subscriber's SS#: _____ ID# / Policy #: _____

I attest that the information that I have given today is correct to the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in my/my child's medical and/or dental health status as well as insurance information.

_____ _____

Signature Date

_____ _____

Name (Please Print) Relationship to Patient