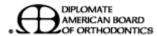


About You	Orthodontic Coverage
Today's Date:/	Orthodontic Coverage: Y N Insurance Co. Name: Insurance Co. Address: Insurance Co. Phone#: Group# (Plan, Local or Policy#): Insured's Name: Insured's Birthdate:// Insured's ID#: Insured's Employer: Secondary Orthodontic Coverage: Y N Dental Coverage: Y N Insurance Co. Name: Insurance Co. Address: Insurance Co. Phone#: Group# (Plan, Local or Policy#): Insured's Name: Relation: Insured's Birthdate://_ Insured's ID#: Insured's Birthdate://_ Insured's ID#: Insured's Employer:
Date of Last Visit: Spouse Information	In the event of an emergency, is there someone who lives near you that we should contact? His/Her Name: Relation: Work#: Home#:
Name:	Medical History
Person Responsible for Account: Work #: Home#: Billing Address: Relation: SS#: Employer: DL#	Do you have a personal physician? Y N Physician's Name: Phone#: Date of Last Visit:
Authorization	
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 this office, use the services of one or more credit reporting services. 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. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. And I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.	



Medical History	Dental History
Are you currently under the care of a physician? Y N Please explain:	What are the main concerns that you would like orthodontics to accomplish?
Are you taking any prescription/over-the-counter drugs? Y N Please list each one:	
For Women: Are you using a prescribed method of birth control? Y N	
Are you pregnant? Y N Week#:	Have you ever been evaluated or had orthodontic treatment before? Y N
Are you nursing? Y N Have you ever had any of the following	Have you ever had a serious/difficult problem associated with any previous dental work? Y N
diseases of medical problems? Y N Abnormal Bleeding Y N Hemophilia	Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Y N
Y N Anemia Y N Hepatitis	Your current dental health is: Good Fair Poor
Y N Artificial Bones/ Y N High/Low Blood Pressure	Do you like your smile? Y N Gums ever bleed? Y N
Joints/Valves Y N Hospitalized for Any Reason	Do you have any speech problems?
Y N Asthma/Arthritis Reason Y N AIDS/HIV+ Y N Kidney Problems	Do you generally breathe through your mouth? Y N
Y N Blood Transfusions Y N Mitral Valve Prolapse	If yes: While Awake? While Asleep?
Y N Cancer/Chemotherapy Y N Psychiatric Problems	Do you have any missing or extra permanent teeth? Y N
Y N Congenital Heart Defect Y N Radiation Treatment Y N Repeated Y N Rheumatic Fever	Have you ever taken Fosamax or any other bisphosphonate? Y N
1 N Diabetes	Have you ever taken Phen-Fen? Y N
To Dimedicy Breating	Do you smoke or use tobacco in any form? Y N
i N Drug/Alconor Abuse	
1 W Emphysema	
V M Cinus Droblems	Lundoustand that the information that I have given to day is
Y N Fever Blisters/Herpes T N Silius Froblems Y N Heart Attack/Stroke Y N Tuberculosis (TB)	I understand that the information that I have given today is correct to the best of my knowledge. I also understand
Y N Heart Murmur Y N Ulcers/Colitis	that this information will be held in the strictest
Y N Heart Surgery/Pacemaker Y N Venereal Disease	confidence and it is my responsibility to inform this office
1 N Heart Surgery/Facemaker	of any changes in my medical status. I authorize the dental
Are you allergic to any of the following?	staff to perform any necessary dental services that I may
Y N Aspirin Y N Erythromycin Y N Penicillin	need during diagnosis and treatment with my informed
Y N Any Metals/ Y N Dental Y N Tetracycline Plastics Anesthetics	consent.
Y N Codeine Y N Latex Y N Other	
Please list any other drugs/materials that you are allergic to:	Signature Date
Our office is HIPPA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.	
This office reserves the right to verify the credit status of	I understand that I am responsible for payment of services
potential patients and/or parents of patients prior to extending	rendered and also responsible for paying any co-payment and
credit for treatment fees and may, at the discretion of the office, use the services of one or more services.	deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits (otherwise
office, ase the services of one of more services.	payable to me) directly to this office.
Signature Date	Signature Date