MOSES ORTHO

About You

Today's Date: _____/_____/_____

Name: _____

Birth date: _____/_____/_____ Age: _____ ○ Male ○ Female

Home Address: _____

_____

○ Single ○ Married ○ Divorced ○ Widowed ○ Separated

Patient's SS #: _____

Home #: _____ Other # _____

Work #: _____ DL#: _____

Email Address: _____

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: _____

Date of Last Visit: _____

Spouse Information

Name: _____

Birth date: _____/_____/_____

Employer: _____

Work #: _____

Person Responsible for Account: _____

Work #: _____ Home#: _____

Billing Address: _____

Relation: _____ SS#: _____

Employer: _____ DL# _____

Orthodontic Coverage

Orthodontic 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 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 Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His/Her Name: _____

Relation: _____

Work#: _____ Home#: _____

Cell#: _____

Medical History

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.

Signature _____ Date _____

16600 SE 15th St. Ste A
Vancouver, WA 98683

American Association of Orthodontists

DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

360.514.0055
mosesorthodontics.com

Medical History

Are you currently under the care of a physician? ○ Y ○ N
Please explain: _____

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#: _____

Are you nursing? ○ Y ○ N

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

○ Y ○ N Abnormal Bleeding
○ Y ○ N Anemia
○ Y ○ N Artificial Bones/ Joints/Valves
○ Y ○ N Asthma/Arthritis
○ Y ○ N AIDS/HIV+
○ Y ○ N Blood Transfusions
○ Y ○ N Cancer/Chemotherapy
○ Y ○ N Congenital Heart Defect
○ Y ○ N Diabetes
○ Y ○ N Difficulty Breathing
○ Y ○ N Drug/Alcohol Abuse
○ Y ○ N Emphysema
○ Y ○ N Epilepsy/Seizures/Fainting
○ Y ○ N Fever Blisters/Herpes
○ Y ○ N Heart Attack/Stroke
○ Y ○ N Heart Murmur
○ Y ○ N Heart Surgery/Pacemaker
○ Y ○ N Hemophilia
○ Y ○ N Hepatitis
○ Y ○ N High/Low Blood Pressure
○ Y ○ N Hospitalized for Any Reason
○ Y ○ N Kidney Problems
○ Y ○ N Mitral Valve Prolapse
○ Y ○ N Psychiatric Problems
○ Y ○ N Radiation Treatment
○ Y ○ N Rheumatic Fever
○ Y ○ N Severe/Frequent Headache
○ Y ○ N Shingles
○ Y ○ N Sickle Cell Disease/Traits
○ Y ○ N Sinus Problems
○ Y ○ N Tuberculosis (TB)
○ Y ○ N Ulcers/Colitis
○ Y ○ N Venereal Disease

Are you allergic to any of the following?

○ Y ○ N Aspirin
○ Y ○ N Any Metals/ Plastics
○ Y ○ N Codeine
○ Y ○ N Erythromycin
○ Y ○ N Dental Anesthetics
○ Y ○ N Latex
○ Y ○ N Penicillin
○ Y ○ N Tetracycline
○ Y ○ N Other

Please list any other drugs/materials that you are allergic to: _____

_____

_____

Dental History

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

_____

_____

_____

Have you ever been evaluated or had orthodontic treatment before? ○ Y ○ N

Have you ever had a serious/difficult problem associated with any previous dental work? ○ Y ○ N

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ○ Y ○ N

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

Do you like your smile? ○ Y ○ N Gums ever bleed? ○ Y ○ N

Do you have any speech problems? _____

Do you generally breathe through your mouth? ○ Y ○ N
If yes: ○ While Awake? ○ While Asleep?

Do you have any missing or extra permanent teeth? ○ Y ○ N

Have you ever taken Fosamax or any other bisphosphonate? ○ Y ○ N

Have you ever taken Phen-Fen? ○ Y ○ N

Do you smoke or use tobacco in any form? ○ Y ○ N

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

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 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 services.

_____
Signature Date

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 payment of the group insurance benefits (otherwise payable to me) directly to this office.

_____
Signature Date