LAFAYETTE ORTHODONTICS

Welcome to our office!

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

_____

About You

Patient's Name:_____

Nickname: _____

Birthdate:____/_____/_____ ☐ **Male** ☐ **Female**

Home Address:_____

_____

SS#:_____ **DL#:**_____

Phone:_(____)_____ **Wk #:** (____)_____

Cell #:(____)_____ **Carrier:**_____

Email:_____

Employer:_____

Occupation:_____

How long there?_____

Marital Status:

□ Single □ Married □ Widowed □ Divorced

Hobbies/Sports:_____

Please list any family members we have seen:

_____

Where & when are best times to reach you?

_____

Insurance Info

If you have Orthodontic Insurance Coverage for the patient, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

_____

Insurance Phone: (____)_____

Insured's ID#:_____

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

General Info

Whom may we thank for referring you?_____

_____

Do You Know Any of our Patients?_____

_____

Spouse Info:

Name: _____

Birth date: _____/_____/_____

Employer: _____

Work #: _____

Person Responsible for Account:

Name:_____

Work #: _____ **Home#:**_____

Billing Address: _____

_____

Relation: _____

SS#: _____ **DL#**_____

Employer: _____

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: _____

LAFAYETTE ORTHODONTICS

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

Are you allergic to any of the following?

☐Y ☐N Aspirin
☐Y ☐N Metals/Plastics
☐Y ☐N Codeine
☐Y ☐N Erythromycin
☐Y ☐N Dental Anesthetic
☐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

General Dentist: _____

Last visit date: _____

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

Have there been any injuries to the face, mouth, teeth or chin? ☐Y ☐N

Do you require antibiotics before dental treatment? ☐Y ☐N

Do you experience any of the following?

☐Y ☐N Ice Chewing
☐Y ☐N Clenching/Grinding Teeth
☐Y ☐N Lip Sucking/Biting
☐Y ☐N Mouth Breather
☐Y ☐N Nail Biting
☐Y ☐N Speech Problems
☐Y ☐N Thumb/Finger Sucking
☐Y ☐N Tongue Thrust
☐Y ☐N Tonsils Removed
☐Y ☐N Snoring
☐Y ☐N Extra/missing teeth

List any musical instruments played: _____

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 _____