NEW PATIENT INFORMATION

Patient Name:________________________________Nickname:_________________________

Date of Birth:________________________Age:_________Sex: Male_______Female_______

Address:____Phone:_______________________
House, apt. # Street

____
City State Zip Code

Referred By:_____________________________Dentist Name:___________________________
Chief Complaint:____
Dentist Phone / Address:____
Parent's Marital Status: Single____Married____Divorced____Widowed____Separated____
Mother's Full Name: (Miss, Mrs., Ms., Dr.)____
Mother's Address: (If Different)____
Date of Birth:_______________E-Mail:______________________________________
Home Phone:________________Work__________________Cell___________________
Employer:____
Father's Full Name: (Mr., Dr.) ____
Father's Address (If Different):____
Date of Birth: ______________E-Mail: ______________________________________
Home Phone: _______________Work __________________Cell __________________
Employer: ____

ORTHODONTIC INSURANCE INFORMATION

Primary Dental Insurance Co.: (Mother, Father)_____________________________________
Insurance Company Phone Number:___________________________
Claim Mailing Address:____
ID#:________________________________SS#:_________________________________
Secondary Dental Insurance Co.: (Mother, Father)____________________________________
Insurance Company Phone Number:___________________________
Claim Mailing Address:____
ID#:________________________________SS#:_________________________________

Signature of **RESPONSIBLE** Party(s) for billing: X____________________________________
X____________________________________

I have received a copy of this office's Notice of Privacy Practices.

Name: (Print)_____________________Signature:______________________Date:_________

OFFICE USE ONLY

___Patient/Guardian refused to sign
___Communications barriers prohibited obtaining the acknowledgement
___An emergency situation prevented us from obtaining acknowledgement
___Other (describe)____

MEDICAL HISTORY

1. Patient's Name: ____
2. Patient's Physician: _________________________ Date of last visit: ______________

	YES	NO
3. Does patient have to be premedicated for dental visits?	___	___
4. Does patient have any allergies to latex or latex based products or any metals?	___	___
5. Is patient under any medical treatment now?	___	___
6. Has patient ever had a blood transfusion?	___	___
7. Does patient have any allergies to medication, seasonal or other?	___	___
8. Has a physician ever informed patient of the following:		
a. Heart Ailment?	___	___
b. Heart Murmur?	___	___
c. High Blood Pressure?	___	___
d. Respiratory Disease?	___	___
e. Diabetes?	___	___
f. Rheumatic Fever?	___	___
g. Arthritis?	___	___
h. Tumors or Growths?	___	___
i. Blood Disease?	___	___
j. Liver Disease?	___	___
k. Kidney Disease?	___	___
l. Stomach Disease?	___	___
m. Intestinal Disease?	___	___
n. Yellow Jaundice or Hepatitis?	___	___
o. Aids or HIV?	___	___
p. Tonsils or Adenoids removed?	___	___
q. Other?	___	___
9. Is patient taking any drugs or medications?	___	___
10. Has patient had any adverse responses to any drugs?	___	___
11. Has patient had wounds heal slowly or present complications?	___	___
12. Does patient have a history of fainting?	___	___

13. **IF ANY OF THE ABOVE ARE ANSWERED YES, or if there are any health concerns we should know about, please explain:** ____
____
____

DENTAL HISTORY

1. Patient's Dentist: ____
2. When was patient's last complete dental exam? Month________Year________

3. If patient is a minor, did either parent have braces?	___	___
4. Is there a family history of crowded teeth?	___	___
5. Is there a family history of impacted (unerupted) upper canines?	___	___
6. Has patient ever had an accident to teeth/jaw?	___	___
7. Does patient clench or grind teeth?	___	___

8. **IF ANY OF THE ABOVE IS ANSWERED YES, or if there are any other concerns, please explain:** ____
____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor at the next appointment.

Signature of patient, parent or guardian: ___________________________Date: _______
Signature of Orthodontist: ______________________________________Date: _______

CONSENT FOR ORTHODONTIC TREATMENT

It is my goal that every patient and parent be fully informed of the benefits and risks of orthodontic treatment. It all begins with a comprehensive evaluation and treatment plan then excellent results are usually achieved with proper compliance. There are some risks and limitations that one should understand before agreeing to undergo orthodontia, however, these seldom pose any problems.

It is of paramount importance that patients maintain excellent oral hygiene, refrain from hard, sticky and excess sugar-containing foods during the course of treatment. Tooth decay, gum disease, and permanent discolorations of enamel can occur as a result of bacteria not being properly brushed away from the teeth and appliances on a regular basis.

The possibility exists that any tooth with a history of trauma, whether it is from an accident or a large filling, may need root canal therapy during orthodontic movement. When teeth are moved with braces, the roots may be shortened, but rarely to the degree that it threatens the health and integrity of the tooth.

The temporomandibular joints may become painful or noisy during orthodontic treatment. The movement of the teeth does not usually cause this. It can be related to past history of trauma and may or may not improve during treatment. Braces do not cure an existing joint disease, nor do they create one.

Teeth that have been straightened have tendency to move back to their original position after braces are removed. Retainers are necessary to hold teeth in position throughout the growing years and for several years in adult patients. One can expect some minor changes to the lower front teeth, which are a normal function of aging, but usually it is minimal and a permanent retainer reduces or eliminates this tendency. Occasionally an individual has a disproportionate amount of growth in one jaw relative to the other, which can contribute to more tooth movement post treatment or in severe cases may warrant jaw surgery. This is a biological phenomenon, which is based on the genetic make-up of the individual and is beyond the control of an orthodontist.

An orthodontist tries to estimate the total time for treatment based on the individual case. There are factors that can lengthen the treatment and effect the result, such as unfavorable growth, poor compliance, excessive breakage of appliances and frequently missed appointments.

Please do not hesitate to ask if you have any questions about this information.

I have read, understand, and received a copy of the above and consent to treatment.

Name:___________________________________ Date:______________________