



"Creating Healthy and Beautiful Smiles"

Member
American Association of
Orthodontics



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Orthodontist

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BOCA RATON LOCATION
9930 Clint Moore Rd., Suite D102
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WELLINGTON LOCATION
3319 State Rd. 7, Suite 211
Wellington, FL 33449

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PATIENT'S INFORMATION

Today's Date: _____

Name: _____
Last First MI Mr. Mrs. Ms. Dr.

I prefer to be called: _____ Male Female

Birthdate: ___/___/___ Age: ___ S/S#: _____

Home Address: _____

Single Married Divorced Widowed Separated

Hm#: _____ Cell#: _____

Wk#: _____ Ext: _____

Email: _____

DL#: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are the best times to reach you _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

General Dentist: _____

Last visit date: _____

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PARENT or SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

Wk#: _____ Ext: _____ S/S#: _____

Birthdate: ___/___/___

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YOUR CHILDREN

NAME OF CHILD	BIRTHDATE
_____	___/___/___
_____	___/___/___
_____	___/___/___
_____	___/___/___

Do they live with you? yes No

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ORTHODONTIC INSURANCE

PRIMARY

Orthodontic Coverage: yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #) _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's SS : _____

Insured's Employer: _____

SECONDARY

Orthodontic Coverage: yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #) _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's SS : _____

Insured's Employer: _____

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

His / Her Name: _____ Relation: _____

Wk #: _____ Hm #: _____

Person responsible for the account: _____

Wk #: _____ Ext: _____ Hm #: _____

Billing Address: _____ Zip _____

Relation: _____ S/S: _____

Employer: _____ DL #: _____

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MEDICAL HISTORY

Do you have a personal physician? yes No

Physician's Name: _____

Phone #: _____ Date of last visit: _____

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MEDICAL HISTORY continued

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain: _____

Are you taking any prescription/over the counter drugs: Yes No

Please list each one: _____

For women: Are you taking birth control pills? Yes No

Are you pregnant? Yes No Week # _____

Are you nursing? Yes No

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

- | | |
|---------------------------------------|---------------------------------------|
| Y N Anaemia/Radiation Treatment | Y N Heart Surgery/Pacemaker |
| Y N Artificial Bones/Joints | Y N Haemophilia/Abnormal Bleeding |
| Y N Artificial Valves | Y N Hepatitis |
| Y N Asthma/Arthritis | Y N High/Low Blood Pressure |
| Y N Blood Transfusion | Y N HIV + AIDS |
| Y N Cancer/Chemotherapy | Y N Hospitalized for Any Reason |
| Y N Congenital Heart Disease | Y N Kidney Problems |
| Y N Diabetes/Tuberculosis | Y N Mitral Valve Prolapse |
| Y N Difficulty Breathing | Y N Psychiatric Problems |
| Y N Drug/Alcohol Abuse | Y N Rheumatic/Scarlet Fever |
| Y N Emphysema/Glaucoma | Y N Severe/Frequent Headaches |
| Y N Epilepsy/Seizures/Fainting Spells | Y N Epilepsy/Seizures/Fainting Spells |
| Y N Fever Blisters/Herpes | Y N Shingles |
| Y N Heart Attack/Stroke | Y N Ulcers/Colitis |
| Y N Heart Murmur | Y N Venereal Disease |

Please list any serious medical condition(s) that you have ever had:

Are you allergic to any of the following?

- | | | |
|-----------------------|------------------------|------------------|
| Y N Aspirin | Y N Dental Anesthetics | Y N Penicillin |
| Y N Any Metal/Plastic | Y N Erythromycin | Y N Tetracycline |
| Y N Codeine | Y N Latex | Y N Other |

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

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ORTHODONTIC INSURANCE

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

Have you ever been evaluated for Orthodontic treatment? Yes No

Have you ever had a serious / difficult problem associated with any previous dental work/ Yes No

Do you now or have you ever experienced pain/ discomfort in your jaw joint (TMJ/TMD)? Yes No

Your current dental health is: Good Fair Poor

Do you like your smile? Yes No

Do your gums ever bleed? Yes No

Have you ever had an injury to your: Mouth Teeth Chin

Do you have any speech problems? _____

Do you generally breath through your mouth? Awake? Asleep?
(Please Check One)

Do you have any missing or extra permanent Teeth? Yes No

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REFERENCES

Do you know of any other family member or friend who would benefit from orthodontic treatment? yes No

Name

Phone Number

I understand that the information that I have given today is correct to the best of my knowledge. I understand that this information will be held by 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



THANK YOU FOR FILLING OUT THIS FORM COMPLETELY.

This office reserves the right to verify the credit status of potential patients and / 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 credit reporting services.

Signature

Date



OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient names herein.

Initials: _____ Date: _____

Doctor's Comments:

