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Constituent American Association of Orthodontists®
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Welcome! Thank you for choosing our office for your orthodontic needs. Our goal is to make your experience as productive and pleasant as possible. We promote preventive care and encourage proper oral hygiene to help you achieve and maintain optimal aesthetics, function, stability and oral health. We are committed to exceeding your expectations. Congratulations, you've taken the first step to obtain a natural, healthy and beautiful smile to last a lifetime!

Date _____ **PATIENT INFORMATION** **Acct #** _____

Patient Name _____ **Nickname** _____ **Sex: M/F** **Birth Date** _____ **Age** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Home# _____ **Cell# & Carrier** _____ **Email** _____@_____

School or Employer _____ **Grade or Occupation** _____

Do You Expect to Move or Transfer in the Near Future? No/Yes **If Yes, When?** _____

How Did You Hear About Us? _____ **Other Family Members or Friends Seen by Us:** _____

Siblings or Children: No/Yes: **Name/Age** _____ **Name/Age** _____ **Name/Age** _____

RESPONSIBLE PARTY INFORMATION

Responsible Party _____ **Relationship to Patient** _____ **Marital Status: S M W D**

Home Address _____ **City** _____ **State** _____ **Zip** _____

Own or Rent? _____ **How Long At This Address?** _____ **Mailing Address (if different)** _____

Social Security# _____ **Birthdate** _____ **Phone** _____ **Email** _____@_____

Driver's License# _____ **Employer** _____ **Occupation** _____ **# of Years Employed** _____

Employer Address _____ **Work Phone** _____

Spouse's Name _____

Social Security# _____ **Birthdate** _____ **Phone** _____ **Email** _____@_____

Driver's License# _____ **Employer** _____ **Occupation** _____ **# of Years Employed** _____

Employer Address _____ **Work Phone** _____

(If Separate Accounts Requested, Please Indicate Additional Responsible Party)

2nd Responsible Party _____ **Relationship to Patient** _____ **Marital Status: S M W D**

Home Address _____ **City** _____ **State** _____ **Zip** _____

Own or Rent? _____ **How Long At This Address?** _____ **Mailing Address (if different)** _____

Social Security# _____ **Birthdate** _____ **Phone** _____ **Email** _____@_____

Driver's License# _____ **Employer** _____ **Occupation** _____ **# of Years Employed** _____

Employer Address _____ **Work Phone** _____

ORTHODONTIC INSURANCE INFORMATION

Primary Insured's Name _____ **Insured's Birthdate** _____ **Insured's SSN** _____

Insurance Company _____ **Insurance Phone** _____ **Group#** _____

Insurance Claim Address _____ **Fax or Website** _____

EMERGENCY CONTACT INFORMATION

Name of Nearest Relative or Friend Not Living with Patient _____ **Address** _____

Home# _____ **Work#** _____ **Cell# & Carrier** _____

MEDICAL INFORMATION

Physician _____ **Date of Last Visit** _____ **Current Medical Status: Good Fair Poor**

Please Circle YES or NO. (If YES, please specify.)

YES NO Are you taking any prescription or over-the-counter medications? _____

YES NO Do you have any allergies (e.g. metal, latex, drug, plastic, or food)? _____

YES NO Do you have history of major illness, hospitalization or serious accident? _____

Please circle any of the following medical conditions that YOU have had or currently have:

AIDS	**Diabetes**	**Handicaps/Disabilities**	**Kidney Disorders**	**Rheumatic Fever**
Arthritis	**Dizziness/Fainting**	**Heart Problems**	**Liver Disorders**	**Sensory Difficulties**
Asthma	**Drug/Alcohol Abuse**	**Hepatitis**	**Musculoskeletal Disorders**	**Speech Problems**
Birth Defect	**Endocrine Disorders**	**Herpes**	**Pneumonia**	**Tobacco Habit**
Blood Disorders	**Epilepsy**	**High or Low Blood Pressure**	**Psychological/Psychiatric Conditions**	**Tuberculosis**
Bone Disorders	**Gastrointestinal Disorders**	**Immunological Disorders**	**Respiratory Disorders**	**Tumor or Cancer**

Are there any other medical / clinical / family conditions or history that we should be aware of? _____

_____

If CHILD, have you reached puberty (girls: menstruation started; boys: voice changed)? NO YES If yes, approximately when? _____

DENTAL HISTORY

Dentist _____ **Date of Last Cleaning** _____ **Current Dental Status: Good Fair Poor**

WHAT CONCERNS YOU MOST ABOUT YOUR TEETH, BITE or SMILE? Why Are You Here Today? _____

_____

YES NO Are you presently in dental pain / discomfort or have tooth sensitivity to pressure, hot, cold or sweet?

YES NO Any history of significant trauma to the face, head, jaw or chin? Chipped or injured teeth?

YES NO Do your gums bleed? Have you ever been treated for gum problems, attachment loss, bone loss or periodontal disease?

YES NO Were you a Natural birth or C-section? ___ Breast-fed? No/Yes for _____months/years Birth Trauma? No/Yes (please specify)_____

Do you have (had) any of the following? (Please check all that apply)

☐ **Adenoidectomy and/or Tonsillectomy** ☐ **Clenching / Grinding** ☐ **Mouth Breathing** ☐ **Sleep Apnea** ☐ **Thumb or Finger Sucking**

☐ **Chewing Snuff / Tobacco Habit** ☐ **Lip Sucking / Biting** ☐ **Nail Biting** ☐ **Speech Therapy** ☐ **TMJ Pain or Discomfort**

☐ **Teeth: Extra or Missing** ☐ **Tongue Thrust or Lisp**

YES NO Have You Been Evaluated For Braces (or Had Braces) Before? _____

If parent of a child, did YOU have prior orthodontics? NO YES If YES, have you experienced relapse (teeth shifted)? NO YES

What you consider to be the main benefit(s) of orthodontic correction?

☐ **Cosmetic** ☐ **Functional** ☐ **Psychological / Emotional** ☐ **Other** _____

Patient's attitude(s) toward orthodontic treatment?

☐ **Enthusiastic** ☐ **Indifferent** ☐ **Apprehensive** ☐ **Other** _____

SIGNATURE

I certify that the information I have provided is complete and correct to the best of my knowledge and that it will be held in the strictest confidence. I understand it is my responsibility to inform this office of changes in medical/dental status. I authorize the orthodontic staff to perform any necessary services for diagnosis and treatment. I give permission for any photographs, X-rays and study models to be used at scientific meetings, presentations and publications of a scientific nature or study group to further the art, science and education of orthodontics. I understand that late payments over 30 days are subject to a finance fee. If applicable, I authorize insurance payment of orthodontic benefits directly to this office as well as authorize release of all information necessary to secure payment. I agree to pay any fees not paid by insurance and all collection fees, should my account become delinquent. I authorize this office to verify my credit history prior to extending credit to me, and that this office may use the services of one or more credit reporting agencies. In case of divorce, I accept that the accompanying parent will pay for services and seek reimbursement from other parent. Finally, I understand that the Notice of Privacy Practice is accessible in the reception area for my review and a copy is provided upon request.

Signature of Patient / Parent or Legal Guardian _____ **Date** _____