Oakwell Farms Orthodontics

Patient Information Form

Patients Name_____Date_____
Last First Middle

Address_____
Street City State Zip

Birthdate_____/_____/_____ School _____ Home Phone (____) _____-_____

If patient is a minor, Name of parent or guardian_____

Whom may we thank for referring you to us? _____

RESPONSIBLE PARTY INFORMATION

Name_____ _____
Last First MI Marital Status

Mailing Address_____
Street City State Zip

How long at this address?_____ Home Ph_____ Work Ph_____
Cell Phone_____ Email Address_____

SS#_____-_____-_____ Birthdate_____-_____-_____ Relationship to patient_____

Employer_____ Occupation_____ Years Employed_____

Spouse's Name_____ Relationship to patient_____

SS#_____-_____-_____ Birthdate_____-_____-_____ Employer_____

Occupation_____ Work phone_____ No. Years Employed_____

DENTAL INSURANCE INFORMATION

Subscriber's Name_____ SS#_____-_____-_____

Insurance Company_____ Group #_____ Phone #_____

Insurance Company Address_____

Do you have dual coverage? (Two insurances?) _____ Yes _____No

Secondary Insurance Company Name & Address_____

Group #_____ Telephone #_____

Name & Phone # of nearest relative <u>NOT</u> in your home_____

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

_____

Have you/child been evaluated or had orthodontic treatment before? _____ Y _____ N
Have there been any injuries to the face, mouth, teeth, or chin? _____ Y _____ N
List any musical instruments played: _____
Have adenoids or tonsils been removed? _____ Y _____ N
Missing/Extra permanent teeth? _____ Y _____ N Pain/Tenderness (TMJ/TMD) _____ Y _____ N
Do you/child brush daily? ____ Y ____ N Floss Daily? ____ Y _____ N Do gums bleed _____ y ____ N
Physician's Name and Phone Number _____
Are you/child under care of a physician? _____ Y _____ N Last Visit _____
List all drugs you/child are currently taking _____
List all drugs that you/child are allergic to _____
List Name & Phone of General Dentist _____
Last Cleaning: _____
CHILDREN: Has puberty begun? _____ Y _____ N Menstruation? _____ Y _____ N
Describe child's physical health _____
WOMEN Are you pregnant? _____ Nursing? _____ Taking oral contraceptives? _____

ADULTS/CHILDREN

Have you/child had any of the following problems? (Circle Y or N)

Y N Abnormal bleeding
Y N Anemia/Radiation treatment
Y N Artificial bones/joints
Y N Asthma
Y N Allergy to plastic/Latex
Y N Blood transfusion
Y N Cancer/Chemotherapy
Y N Fever blisters/Herpes
Y N Shingles
Y N Severe/Frequent headaches
Y N Venereal Disease
Y N Epilepsy/Seizures/Fainting
Y N Ulcers/Colitis
Y N Sinus problems

Y N Diabetes
Y N Hearing Impairment
Y N High/Low blood pressure
Y N HIV+/AIDS
Y N Hospitalized? Reason? _____
Y N Kidney problems
Y N Psychiatric problems
Y N Emphysema/Glaucoma
Y N Drug/Alcohol Abuse
Y N Rheumatic fever? Pre-med Y N
Y N Heart attack/stroke/murmur? Pre-med Y N
Y N Mitral valve prolapsed? Pre-med Y N
Y N Heart surgery/Pacemaker? Pre-med Y N
Y N Congenital Heart Defect? Pre-med Y N

Please list any serious medical condition(s)

_____

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 (or my child) may need during diagnosis and treatment with my informed consent. I give consent for this office to give school officials information in relation to attendance when questioned.
I authorize this office to file insurance claims and collect payment according to procedure once treatment begins. I also understand that if my coverage changes or terminates during treatment. I will assume responsibility of the account.

Signature Date