BATES ORTHODONTICS

Welcome to our office. Please fill out both sides of this form.

About You:

Today's Date: ____/____/____ ☐ Male ☐ Female

Name: _____
First MI Last

Preferred Name: _____

Date of Birth: ____/____/____ Age: _____

Preferred Phone Number: _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____

Email: _____

Preferred method to contact: _____

Driver's License #: _____ State: _____

Social Security Number: _____

Employer: _____

Work Phone Number: _____

Whom may we thank for you referring you?

_____

Other family members seen by us:

_____

Spouse/Emergency Contact Information:

Name: _____

Relation: _____

Home #: _____ Cell #: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Person Responsible for Account:

Are you responsible for your account? ☐ Yes ☐ No

If not, please enter information below:

Name: _____ Relation: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____

Email: _____

Preferred method to contact: _____

Employer: _____

Work Phone Number: _____

Driver's License #: _____ State: _____

Social Security Number: _____

Insurance Information:

Primary

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Policy/Subscriber ID: _____

Policy Holder's Name: _____

Relationship to Patient: _____

Policy Holder's Date of Birth: ____/____/____

Policy Holder's SSN: _____

Secondary

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Policy/Subscriber ID: _____

Policy Holder's Name: _____

Relationship to Patient: _____

Policy Holder's Date of Birth: ____/____/____

Policy Holder's SSN: _____

Dental History:

General Dentist: _____

Last Visit: _____

Have you ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No

If Yes, When: _____

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

☐ Yes ☐ No

If So, When: _____

Have you been informed of any missing or extra permanent teeth?

☐ Yes ☐ No

Have you ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ☐ Yes ☐ No

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

_____

_____

Do you have any of the following habits?

- ☐ Clenching/Grinding Teeth
- ☐ Lip Sucking/Biting
- ☐ Thumb/Finger Sucking
- ☐ Tongue Thrust
- ☐ Speech Problems
- ☐ Mouth Breathing

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

_____

Signature Date

I authorize doctor or designated staff to take x-rays deemed appropriate to make a thorough diagnosis of orthodontic needs:

☐ Yes ☐ No

_____

Signature Date

Medical History:

Have you ever had?

☐ Y ☐ No Abnormal Bleeding
☐ Y ☐ No ADD/ADHD
☐ Y ☐ No Diabetes
☐ Y ☐ No Asthma
☐ Y ☐ No Bone Disorders
☐ Y ☐ No Handicaps/Disabilities
☐ Y ☐ No AIDS/HIV
☐ Y ☐ No Epilepsy
☐ Y ☐ No Kidney Problems
☐ Y ☐ No Liver Problems
☐ Y ☐ No Hepatitis
☐ Y ☐ No Lupus
☐ Y ☐ No Heart Condition
☐ Y ☐ No Tuberculosis
☐ Y ☐ No Sickle Cell Disease
☐ Y ☐ No Allergic to Latex/ Metals
☐ Y ☐ No Allergies to any Drugs
☐ Y ☐ No Food Allergy

If yes to above, please give details:

_____

Your Physician: _____

Are you under the care of a physician? ☐ Y ☐ No

Please list all medications you are currently taking:

_____

Are you currently taking a bisphosphonate for osteoporosis?

☐ Y ☐ N

If so, which ones: _____

Please list any additional health information we should know:

For Woman:

Are you pregnant? ☐ Yes ☐ No

Week Number: _____

Are you nursing? ☐ Yes ☐ No

Please list any additional health information we should know:

_____

_____

Additional person we may discuss medical and financial information with:

Name: _____ Relation: _____

☐ Medical ☐ Financial