Welcome to Our Club of Smiles!

Who is Completing this Form?

Name ____

Date ______________________________

Signature ____________________________________

Who will We be Seeing?

Patient Name ____

First Last MI

But I would rather be called....______________________ Gender (circle one) M F

Address ____

City___________________________ State _____________ Zip Code ______________

Phone ( ) _________________Birthdate __________________ Age ___________

School or Workplace ____

Hobbies or Interests ____

Who will be Responsible for *Treatment Decisions?*

Financial information will be requested at a later date.

Name ____

First Last MI

Address ____

City________________________ State __________ Zip Code __________

Phone ( ) ________________ Alternate Phone ( )____________________

Relationship to Patient_________________

Please list an additional person who can be responsible for the patient's treatment decisions.

Their Name _______________________________ Their phone ( ) ________________

How did You find Us?

(Please Check One)

Your Dentist ______

From a friend or relative_____

*Whom may we thank?*_______________________

Family Member is/was a patient ______

Phonebook ______

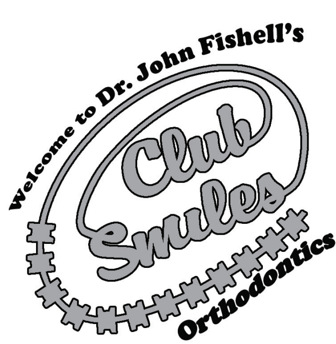
Advertisement ______

Internet ______

Office Sign ______

Other ______

*If other:*_________________



Patient Name ________________________ *Date*__________________

Initial (person completing this form) ________________

We Need to Know just a Little Bit More....

How are You Feeling?

Is the patient in good health? Yes ____ No ____ Details ______________________________

Does the patient have a history of significant illness of disease? Yes ____ No ____ Details ______________________________

Is the patient allergic to any drugs or medications? Yes ____ No ____ Details ______________________________

Does the patient have any environmental allergies? Yes ____ No ____ Details ______________________________

Does the patient have any history of heart problems? Yes ____ No ____ Details ______________________________

Does the patient have any history of rheumatic fever or heart murmur? Yes ____ No ____ Details ______________________________

Does the patient have any history of bleeding disorders? Yes ____ No ____ Details ______________________________

Does the patient take premedication for dental cleanings? Yes ____ No ____ Details ______________________________

Is there any condition that may affect the patients orthodontic care? Yes ____ No ____ Details ______________________________

Is the patient taking any medications currently? Yes ____ No ____ Details ______________________________

Who is Your Dentist?

Dentist Name ____ For how many years? ________

Dentist Address ____

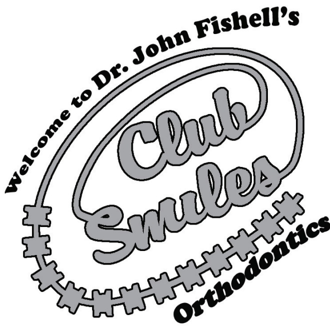
Date of last dental check-up ____________________

Has the patient ever had any injury to the face, mouth, or teeth? Yes ____ No ____
If yes, please explan ____

Does the patient have any known dental problems? Yes ____ No ____
If yes, please explan ____

Reason for seeking an orthodontic evaluation ____

Has another orthodontist been consulted? Yes ____ No ____
If yes, whom? ____



Patient Name ________________________ *Date*__________________

Initial (person completing this form) ________________

Do you have Insurance Coverage?

***Please fill out all information below as completely and accurately as possible in order to obtain correct verfication and payment from your insurance in a timely manner.**

Who is the Primary Insurance Under?

Member Name __________________________________ Member's Birthdate _______________
First Last MI

Member's S.S. Number ______________________ Member's ID # ____________________

Relationship to Patient _______________________ Patient's Birthdate _____________________

Insurance Company Name ____

*Note: If Delta Dental, please specify which location. (Ex: Delta Dental **of PA**)*

Insurance Company Phone ( ) _______________ Group Number (on card) ________________

Where Do they Work?

Employer ____

Employer Address ____

City ___________________________________ State ___________ Zip Code ________________

Employer Phone ( ) _____________________

Do you have additional Insurance Coverage?

Who is the Secondary Insurance Under?

Member Name __________________________________ Member's Birthdate _______________
First Last MI

Member's S.S. Number ______________________ Member's ID # ____________________

Relationship to Patient _______________________ Patient's Birthdate _____________________

Insuance Company Name ____

*Note: If Delta Dental, please specify which location. (Ex: Delta Dental **of PA**)*

Insurance Company Phone ( ) _______________ Group Number (on card) ________________

Where Do they Work?

Employer ____

Employer Address ____

City ___________________________________ State ___________ Zip Code ________________

Employer Phone ( ) _____________________