

PATIENT INFORMATION

Date _____

Patient's name _____
Last First Middle

Address _____
Street City Zip

Nickname _____ Birthdate _____ Social Security # _____

School _____ Sports/Hobbies _____

Parent(s) or guardian(s) name _____

Whom may we thank for referring you to our office? _____

Please list name of any friends or family current in the practice: _____

RESPONSIBLE PARTY INFORMATION

Name _____
Last First Middle

Address _____
Street City Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

How long at this address? _____ Home phone _____ Work phone _____

Cell/other phone _____ Email address _____

Employer _____ Occupation _____ No. years employed _____

Significant Other Name _____ Relationship to Patient _____

Employer _____ Occupation _____ No. years employed _____

Social Security # _____ Birthdate _____ Work Phone _____

DENTAL INSURANCE INFORMATION

Insured's Name _____ Insured's Social Security #/ID Number _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____

Do you have dual coverage? Yes _____ No _____ If yes:

Insured's Name _____ Insured's Social Security #/ID Number _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address _____
Street City Zip

Phone _____

RELEASE

I authorize release of any information regarding my or my child's orthodontic treatment to the dental and/or medical insurance company.

Signature _____ Date _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____
Please circle Yes or No (If Yes, please fill in details)

- Yes No Is the patient taking any medication? _____
- Yes No Is the patient allergic to any medication? _____
- Yes No Does the patient have any known allergies (e.g. latex, metal, etc.) _____
- Yes No History of a major illness? _____
- Yes No Has the patient had any operations? _____
- Yes No Ever been involved in a serious accident? _____
- Yes No Have seen a physician in the last 12 months? Why? _____
- Female Patients only:
- Yes No Has menstruation started? _____
- Yes No Is the patient pregnant? _____

Circle any of the medical conditions below that the patient has had or currently has.

- | | | | |
|------------------------------|----------------------------|--------------------------|------------------------|
| Abnormal bleeding/Hemophilia | Diabetes | Hepatitis/Liver problems | Pneumonia |
| Anemia | Dizziness | Herpes | Prolonged Bleeding |
| Arthritis | Epilepsy | High Blood Pressure | Radiation/Chemotherapy |
| Asthma or Hayfever | Gastrointestinal Disorders | HIV / Aids | Rheumatic Fever |
| Bone Disorders | Heart Problems | Kidney problems | Tuberculosis |
| Congenital Heart Defect | Heart Murmur | Nervous Disorders | Tumor or Cancer |
- Are there any medical conditions we have not discussed that you feel we should be aware of? _____

DENTAL HISTORY

General Dentist _____ Date of last visit _____
What is the patient's main orthodontic concern? _____

Please circle Yes or No (If Yes, please fill in details)

- Yes No Requires antibiotic pre-medication before any dental procedures? _____
- Yes No Has the patient ever seen an orthodontist? If yes, who and when? _____
- Yes No What is the patient's attitude toward receiving orthodontic treatment? _____
- Yes No Has anyone in the family received orthodontic treatment? _____
- Yes No Is the patient sensitive or self-conscious about his/her teeth? _____
- Yes No Speech problems/therapy? _____
- Yes No Oral habits (thumb/finger sucking, tongue thrust, lip/nail biting, etc.)? _____
- Yes No Mouth breather? _____
- Yes No Grind/clench teeth? _____
- Yes No Snores during sleep? _____
- Yes No Teeth or jaws ever feel uncomfortable first thing in the morning? _____
- Yes No Experience jaw clicking or popping? _____
- Yes No Experience "tension" headaches? _____
- Yes No Injury to face, jaw, teeth, or mouth? _____
- Yes No Has the patient ever lost or chipped any teeth? _____
- Yes No Any missing or extra permanent teeth? _____
- Yes No Is the patient presently in any dental pain? _____
- Yes No Ever experienced any unfavorable reaction to dentistry? _____
- Yes No Do gums bleed when brushing? _____
- Yes No Does the patient need extra help with instructions? _____

Are there any dental conditions we have not discussed that you feel we should be aware of? _____

Yes No Are you aware that some appointments will be during school/work hours? _____

WAIVER

I have read the above questions and understand them. I have truthfully answered all the above questions and agree to inform MPowered Smiles Orthodontics PC and Dr. Milena Bulic of any changes in my/my child's medical or dental history. I will not hold my orthodontist or any member of her staff responsible for any errors or omissions that I have made in completion of this form.

Signature _____ Date _____