WELCOME TO

mildeFAMILY ORTHODONTICS

About You

Today's Date:_____

Name:_____
LAST FIRST MI

I prefer to be called:_____ ☐ Male ☐ Female

Birthdate: _____/_____/_____ Age: _____

Home Address _____

_____
CITY STATE ZIP

Home Phone _____

Work Phone_____

Employer: _____

Employer's Address: _____

How long there?_____Occupation _____

Where & When are best times to reach you? _____

Whom may we THANK for referring you? _____

Other family members seen by us: _____

General Dentist: _____

Last Visit Date: _____

Spouse Information

His/Her Name: _____

Employer: _____

Work Phone_____Ext. _____

Employer: _____

Birthdate:_____

Emergency Contact

Name:_____Relation:_____

Home Phone _____

Work Phone_____

Person Responsible for Account

Name:_____Relation:_____

Billing Address:_____

_____
CITY STATE ZIP

Work Phone_____Ext. _____

Home Phone _____

Employer: _____

DL#: _____

Primary Orthodontic Insurance

Orthodontic Coverage: ☐ Yes ☐ No

Insurance Co. Name:_____

Insurance Co. Address: _____

Insurance Co. Phone #:_____

Group # (Plan, Local or Policy #) _____

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthdate: _____/_____/_____SS# (If Delta Dental): _____

Insured's Employer: _____

Secondary Orthodontic Insurance

Orthodontic Coverage: ☐ Yes ☐ No

Insurance Co. Name:_____

Insurance Co. Address: _____

Insurance Co. Phone #:_____

Group # (Plan, Local or Policy #) _____

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthdate: _____/_____/_____SS# (If Delta Dental): _____

Insured's Employer: _____

THANK YOU FOR FILLING OUT THIS FORM COMPLETELY

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

CONTINUED ON BACK OF FORM

Medical History

Name of personal physician?_____

Phone #:_____Date of Last Visit _____

Have you ever taken prescription medication for weight reduction? This would include: Fen-Phen (Fenfluramine +Phentermine), Pondimin (Fenfluramine), Redux (Dexfenfluramine) ☐ Yes ☐ No

Have you ever taken bisphosphonate medication for osteoporosis? This would include: Fosamax, Boniva, Actonel, Reclast (zoledronic acid) ☐ Yes ☐ No

Are you or could you be pregnant? ☐ Yes ☐ No

Your current physical health: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Are you taking any prescription/over-the-counter drugs? ☐ Yes ☐ No

Please list each one _____

_____

Have you ever had any of the following diseases or medical problems?

- **Y N** Heart Attack/Stroke
- **Y N** Cancer/Chemotherapy
- **Y N** Heart Murmur
- **Y N** Rheumatic Fever
- **Y N** HIV+/AIDS
- **Y N** Heart Surgery/Pacemaker
- **Y N** Shingles
- **Y N** Damaged Heart Valves/ Mitral Valve Prolapse
- **Y N** Kidney Problems
- **Y N** Artificial Bones/Joints
- **Y N** Sinus Problems
- **Y N** High/Low Blood Pressue
- **Y N** Fever Blisters
- **Y N** Severe/Frequent Headaches
- **Y N** Psychiatric Problems
- **Y N** Epilepsy/Seizures/Fainting Spells
- **Y N** Diabetes/Tuberculosis (TB)
- **Y N** Drug/Alcohol Abuse
- **Y N** Venereal Disease
- **Y N** Hemophilia/Abnormal Bleeding
- **Y N** Ulcers/Colitis
- **Y N** Congenital Heart Defect
- **Y N** Anemia/Radiation Treatment
- **Y N** Asthma/Arthritis
- **Y N** Difficulty Breathing
- **Y N** Hospitalized for Any Reason
- **Y N** Hepatitis
- **Y N** Emphysema/Glaucoma
- **Y N** Osteoporosis

Please list any medical condition(s) that you have ever had:

_____

Are you allergic to any of the following items?

- **Y N** Penicillin
- **Y N** Aspirin
- **Y N** Erythromycin
- **Y N** Tetracycline
- **Y N** Dental Anesthetics
- **Y N** Codeine
- **Y N** Latex
- **Y N** Any Metal/Plastic
- **Y N** Other

Please list any other drugs that you are allergic to: _____

_____

Dental History

What would you like orthodontic treatment to accomplish?

_____

_____

_____

Have you ever had or been evaluated for orthodontic treatment?

☐ Yes ☐ No

Have you ever had a serious/difficult problem associated with any previous dental work?

☐ Yes ☐ No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)?

☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had an injury to your: Mouth Teeth Chin (Please Circle)

Do you have any speech problems?_____

_____

Do you generally breathe through your mouth?

Awake? ☐ Yes ☐ No Asleep? ☐ Yes ☐ No (Please Circle One)

Do you have any missing or extra permanent teeth? ☐ Yes ☐ No

Patient Responsibility

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 of confidences, and it is my responsibility to inform this office of any changes in my medical status. I have reviewed my medical history and certify that it is accurate and that there have been no changes since the date of the last signature.

Signature _____

Date _____

OFFICE USE ONLY

I verbally reviewed the medical/dental information with the patient named herein. Initials_____ Date_____

Doctor's Comments: _____

_____

_____

_____

_____