

DATE: _____

Responsible Party Information- Confidential

Full Name _____ Marital Status _____

Last First Middle

Residence _____ Own Rent

Street City State Zip

Mailing Address _____ Email _____

Street City State Zip

How long at this address _____

Previous Address (if less than 3 years) Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security# _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____

Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____ Cell Phone _____

Patient Information - Confidential

Patient's Full Name _____ Male/ Female _____

Last First Middle

Address _____

Street City State Zip

Home Phone _____ Birthdate _____ Age _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____ School _____

Patient's General Dentist _____ Whom may we thank for referring you to our office? _____

Have we seen anyone else in your family before? _____ If yes, please list: _____

Emergency Contact _____ Address/Phone # _____

Email address for on-line access and appointment reminders via email: _____

Dental Insurance Information (Not Medical Insurance)

Subscriber's Name: _____ Subscriber's Birth Date: _____ Subscriber's SS# _____

Employer/Group Name: _____ Subscriber's ID No. _____ Relationship to Patient: _____

Subscriber's Home Address: _____ Subscriber's Phone: _____

Insurance Company _____ Insurance Phone # _____

Insurance Co. Address _____ Group No. _____

Do you have dual coverage? (SECONDARY INSURANCE) NO YES If so:

Subscriber's Name: _____ Subscriber's Birth Date: _____ Subscriber's SS# _____

Employer/Group Name: _____ Subscriber's ID No. _____ Relationship to Patient: _____

Subscriber's Home Address: _____ Subscriber's Phone: _____

Insurance Company _____ Insurance Phone # _____

Insurance Co. Address _____ Group No. _____

I understand that where appropriate, credit bureau reports will be obtained. I authorize Derby Orthodontics to perform an examination & x-rays for treatment.
I certify that the information on this form is complete and true to the best of my knowledge.

Signature (Parent's signature if minor) _____ Print Name _____ Date _____

(TURN OVER)

Patient Medical Information

Does patient have a speech problem and if so, receiving speech therapy? NO YES
Has patient had their tonsils or adenoids removed? NO YES
Is patient presently under the care of a physician or taking medication? NO YES Patient's Physician: Dr. _____
If so, what? _____
Has patient ever had an unusual reaction to any drug? NO YES If so, what? _____

Does patient require medication prior to any dental procedure? NO YES If so, why? _____
Has patient had any of the following?

- | | | | |
|-----------------------|---------------------------|-----------------------------------------------------------------------------------------------|------------------------------|
| [1] Arthritis | [10] Diabetes | [19] Major surgery | [26] Osteoporosis |
| [2] Anemia | [11] Frequent colds | [20] Tuberculosis | [27] Taking Bisphosphonates? |
| [3] Bleeding problem | [12] Asthma | [21] Heart trouble | |
| [4] Epilepsy/Seizures | [13] Rheumatic Fever | [22] Thyroid or Hormonal imbalance | |
| [5] Nervous disorder | [14] Immune Deficiency | [23] Any other serious medical problems? | |
| [6] Hyperactivity | [15] Ulcers | [24] Have you ever had a concussion? <input type="checkbox"/> NO <input type="checkbox"/> YES | |
| [7] Hepatitis | [16] Herpes/Oral-facial | [25] Are you active in sports? <input type="checkbox"/> NO <input type="checkbox"/> YES | |
| [8] Venereal disease | [17] Allergies/Sinus | If so, what sports? _____ | |
| [9] LATEX ALLERGY | [18] METAL/NICKEL ALLERGY | | |

PLEASE CHECK ALL THAT APPLY:

- Prosthetic cardiac valve or prosthetic material used for cardiac valve repair.
- Previous infective endocarditis.
- Congenital heart disease (CHD) & unrepaired cyanotic CHD, including palliative shunts & conduits; completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter intervention, during the first 6 months after the procedure; & repaired CHD with residual defects at the site or adjacent to the site of a prosthetic patch or prosthetic device.
- Cardiac transplant recipients who develop cardiac valvulopathy.

Patient Dental History

Patient's General Dentist: Dr. _____

Does the patient presently suck their thumb or fingers? NO YES

Does the patient breathe mostly through the mouth? NO YES

Does the patient snore often? NO YES

Has the patient ever received a severe blow resulting in injury to the teeth or jaws? NO YES
 If yes, please write in details _____

Does the patient grind their teeth at night? NO YES

In the past, has the patient ever complained of (please circle) clicking popping stiffness soreness in the jaw or muscles of the mouth?
 NO YES

Episodes when the jaw would not open or close normally? NO YES

Pain or discomfort in the front of the ear? NO YES

Headaches, neck and or back pain? NO YES
 If yes, please write date and details _____

Has patient ever had orthodontic treatment or worn a retainer before? NO YES

Would patient object to wearing orthodontic appliances/braces should they be indicated? NO YES

What is patient's or parents' primary concern? _____

OFFICE USE ONLY

HIPAA CONSENT SIGNED

Date: _____ Patient name: _____ Adult present: _____

Records: Pano _____ Ceph _____ Pics _____ Model# _____

Diagnosis:

Class _____	OJ _____	OB _____	X-Bite _____	Buccal
Upper spacing _____ mm	Lower spacing _____ mm			Anterior
Upper crowding _____ mm	Lower crowding _____ mm			

Midline R | | | | | | | | L Missing teeth | Impacted | Extractions |

EXBO/SURGERY: _____ Surgeon: _____ Send Disc _____

Notes: _____

Tx Plan: OBS1 OBS2 OBS3 OBS4 Limited Tx-Up/Lo ULA/LLA Ph 1 Full Tx -HERB RPE APP _____ Full Tx w/surgery Invisalign

1st Insurance Benefit: _____ pd @ _____ % 2nd Insurance Benefit: _____ pd @ _____ %
Est Tx Time _____ mos Dis: _____ ICFD _____ FAM _____ PRO _____ COUR _____ PIF