OrthoCare™ Orthodontics

ADULT PATIENT INFORMATION

Date_____

Patient's name _____
First Middle Last

Address _____
Street City/State Zip

Home Phone (_____) _____Gender _____ Female _____Male Age _____

Nickname_____ Birthdate_____Social Security #_____

Email Address_____Marital Status: Single___Married___Widowed___Separated___Divorced___

Employer_____Occupation_____Work phone(____)_____

Spouse's Name_____ Social Security #_____Birthdate_____

Employer_____ Occupation_____

Cell Phone (____)_____ Work Phone(____)_____

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

Have any family members been previously treated at our office? ____Yes____ No

Name: _____ Name: _____ Name: _____

DENTAL INSURANCE INFORMATION

Insured's Name_____ Insured's Social Security #_____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No._____

Do you have Orthodontic coverage? ____Yes___No. If yes what is your benefits? Lifetime maximum:_____

Deductible_____Amount used_____Payable at what %_____Payments made:_____Mthly_____Qtly

Do you have dual coverage? Yes_____ No_____ If yes, add insurance information below:

Insured's Name_____ Insured's Social Security #_____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No._____

Do you have Orthodontic coverage? ____Yes___No. If yes what is your benefits? Lifetime maximum:_____

Deductible_____Amount used_____Payable at what %_____Payments made:_____Mthly_____Qtly

I authorize the release of any information related to this claim and hereby assign all benefits to Dr. Ford S. Cooper/OrthoCare.

Signature: _____**Date:** _____

MEDICAL HISTORY

Physician_____ Date of Last Visit_____

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

Yes No Are you taking any medications? _____

Yes No Are you allergic to any medications? _____

Yes No Are you allergic to any foods? _____

Yes No Are you allergic to latex? _____

Yes No Are you allergic to metals? _____

Yes No Are you allergic to acrylic? _____

Yes No Are you allergic to any anesthetics? _____

Yes No History of major illness? _____

Yes No Have you had any operations? _____

Yes No Ever been involved in a serious accident? _____

Yes No Have seen a physician in the last 12 months?_____

Yes No Do you smoke or chew tobacco? _____

Female Patients only:

Yes No Are you pregnant? _____

Circle any of the medical conditions below that you have had or currently have.

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? _____

_____

_____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Home address _____
Street City/State Zip

Phone(_____)_____

DENTAL HISTORY

General Dentist _____ Date of last cleaning _____

What are your chief orthodontic concerns? _____

Have you ever seen an orthodontist? If yes, who and when? _____

Yes No Are you presently in any dental pain? _____

Yes No Ever experienced any unfavorable reaction to dentistry? _____

Yes No Have you ever lost or chipped any teeth? _____

Yes No Have there been any injuries to face, mouth, or teeth? _____

Yes No Is any part of your mouth sensitive to temperature? Where? _____

Yes No Is any part of your mouth sensitive to pressure? Where? _____

Yes No Do gums bleed when brushing? _____

Yes No Any type of thumb or tongue habit? _____

Yes No Are you a mouth breather? _____

Yes No Soreness in jaw muscles or face muscles? _____

Yes No Experience jaw clicking or popping? _____

Yes No Aware of clenching or grinding teeth during the day? _____

Yes No Experience "tension" headaches? _____

Yes No Have you ever experienced chronic ringing in the ears? _____

Yes No Are you sensitive or self-conscious about his/her teeth? _____

Yes No Have you ever been treated for "TMD' or "TMJ" problems? _____

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

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I also understand that my picture may be used for social media purposes. In addition, I authorize Dr**.** _____ to perform a complete orthodontic evaluation.

Signature: _____ **Date:** _____

Office use only

I have verbally reviewed the medical/dental information above with the patient named herein. Staff signature: _____

Doctor's signature: _____ Date: _____

Medical/Dental history update:
1. Date: _____ Signature: _____ 2. Date: _____ Signature: _____

3. Date: _____ Signature: _____ 4. Date: _____ Signature: _____