OrthoCare™ Orthodontics

PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Date_____

Patient's name _____
First Middle Last

Address _____
Street City/State Zip

Home Phone (_____) _____Gender _____ Female _____Male Age _____

Nickname_____ Birthdate_____Social Security # _____

School_____Sports/Hobbies _____

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:_____

Who is with the child today? _____Relationship_____

Do you have custody of this patient? ___Yes___No. If not who does? _____ Relationship_____

Mother's name: _____ Responsible party? _____Yes_____No
First M.I. Last

Cell Phone:(_____) _____ Work Phone:(_____) _____

Email Address: _____ Best method of reminders _____Phone_____Text_____Email

Father's name: _____ Responsible party? _____Yes_____No
First M.I. Last

Cell Phone:(_____) _____ Work Phone:(_____) _____

Email Address: _____ Best method of reminders _____Phone_____Text_____Email

RESPONSIBLE PARTY INFORMATION

Name_____
First M.I. Last

Address _____
Street City /State Zip

Home phone(_____) _____ Work phone(_____) _____

Cell/other phone(_____)_____ Email address_____

Social Security #_____ Birthdate_____ Relationship to Patient _____

Employer_____Occupation_____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Home address _____
Street City/State Zip

Phone(_____)_____

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	Is the patient taking any medications?	_____
Yes	No	Is the patient allergic to any medications?	_____
Yes	No	Is the patient allergic to any foods?	_____
Yes	No	Is the patient allergic to latex?	_____
Yes	No	Is the patient allergic to metals?	_____
Yes	No	Is the patient allergic to acrylic?	_____
Yes	No	Is the patient allergic to any anesthetics?	_____
Yes	No	History of 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?	_____
Yes	No	Does patient smoke or chew tobacco?	_____
Female Patients only:			
Yes	No	Has menstruation started? When?	_____
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 cleaning _____

What are your chief orthodontic concerns? _____

Has the patient ever seen an orthodontist? If yes, who and when? _____

Yes No Is the patient presently in any dental pain? _____

Yes No Ever experienced any unfavorable reaction to dentistry? _____

Yes No Has the patient ever lost or chipped any teeth? _____

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

Yes No Is any part of patient's mouth sensitive to temperature? Where? _____

Yes No Is any part of patient's mouth sensitive to pressure? Where? _____

Yes No Do gums bleed when brushing? _____

Yes No Any type of thumb or tongue habit? _____

Yes No Is the patient 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 Has the patient ever experienced chronic ringing in the ears? _____

Yes No Is the patient sensitive or self-conscious about his/her teeth? _____

Yes No Has patient 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 child's 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 parent/guardian and patient named herein. Staff initials:_____

Doctor's signature: _____ Date: _____

Medical/Dental history update:
1. Date: _____Signature: _____2. Date: _____ Signature: _____

3. Date: _____Signature: _____4. Date: _____ Signature: _____