Premier Smiles Orthodontics

WELCOME

PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Date: _____

Patient's Name: _____
last first middle

Address: _____
Street City Zip

Nickname: _____ Birthdate: _____

Social Security # _____

School: _____
Sports/ Hobbies: _____
Parent/ Guardian Name: _____
Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

Name: _____
last first middle
Residence: _____
street city zip
Mailing Address: _____
street city zip
How long at this address? _____
Previous Address (if less than 3 years): _____
Home Phone: _____ Work Phone: _____
Cell/ other Phone: _____
Email Address: _____
Social Security # _____ Birthdate: _____
Relationship to Patient: _____
Employer: _____ Occupation: _____
No. of years employed: _____

Spouse's Name: _____
Relationship to patient: _____
Employer: _____
Occupation: _____ No. of years employed: _____
Social Security #: _____ Birthdate: _____

DENTAL INSURANCE INFORMATION

Insured's Name: _____

Insurance Company: _____
Insurance Co. Address: _____
Do you have dual coverage? Yes: ____ No: ____
Insured's Name: _____
Insurance Company: _____
Insurance Co. Address: _____

Insured's Social Security #: _____
Group No.: _____ Local No.: _____
Phone Number: _____
If yes:
Insured's Social Security #: _____
Group No.: _____ Local No.: _____
Phone Number: _____

EMERGENCY INFORMATION

Name of nearest relative not living with you: _____

Complete Address: _____
Street City Zip

Phone Number: _____

I understand that, where appropriate, credit bureau reports may be obtained.

Parent Signature: _____

Updates (date & initial): _____

Dental History

General Dentist: _____
Date of last visit: _____
What concerns you most about your teeth?
_____
_____

Is the patient currently experiencing any dental pain?	□ Yes □ No
Ever experienced any unfavorable reaction to dentistry?	□ Yes □ No
Has the patient ever lost or chipped a tooth?	□ Yes □ No
Have there ever been any injuries to the face, mouth, or teeth?	□ Yes □ No
Is there any part of your mouth that is sensitive to temperature?	□ Yes □ No
Is there any part of your mouth that is sensitive to pressure?	□ Yes □ No
Do your gums bleed when brushing your teeth?	□ Yes □ No
Any type of thumb or tongue habits?	□ Yes □ No
Is the patient a mouth breather?	□ 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? _____ _____	
Has anyone in the family received orthodontic treatment? How did they feel about the results? _____ _____	□ Yes □ No
Do teeth or jaw ever feel uncomfortable in the morning?	□ Yes □ No
Ever experienced jaw clicking or popping?	□ Yes □ No
Aware of any clenching or grinding of teeth during the day?	□ Yes □ No
Ever experienced "tension" headaches?	□ Yes □ No
Has the patient ever experienced chronic ringing in the ears?	□ Yes □ No
Does the patient need extra help with instructions?	□ Yes □ No
Is the patient sensitive or self-conscious about his/her teeth?	□ Yes □ No
Are you aware that some appointments will be during school hours?	□ Yes □ No

Medical History

Physician: _____
Date of last visit: _____
Address: _____
Phone Number: _____

Please check Yes or No to the following (If yes, please fill in details)

Is the patient currently taking any medications? _____	□ Yes □ No
Is the patient allergic to any medications? _____	□ Yes □ No
History of major illnesses? _____ _____	□ Yes □ No
Has the patient ever had any operations? _____	□ Yes □ No
Has seen in a physician in the last 12 months? _____	□ Yes □ No
FEMALE PATIENTS ONLY	
Is the patient pregnant?	□ Yes □ No
Has menstruation started?	□ Yes □ No

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 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 or lifetime and there can be some movement 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 have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. _____ to preform a complete orthodontic evaluation.

_____ _____
Signature Date