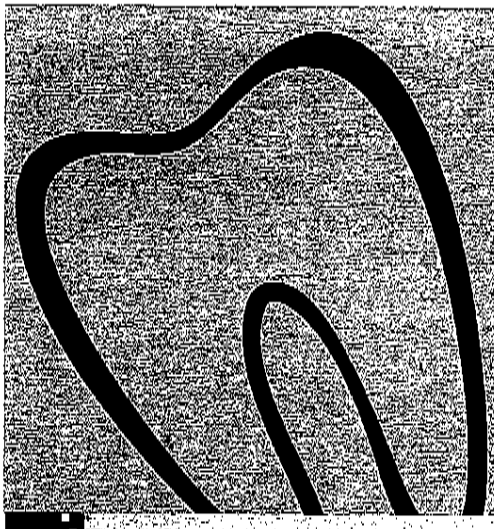

WELCOME

To Schouten Orthodontics

1 Tell Us About You

Today's Date: ___/___/___

Email Address: _____

Name: _____

I prefer to be called: _____ ☐Male ☐Female

Birthdate: ___/___/___ Age: ____ SS#: _____

Home Address: _____

_____

☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Hm #: (___) _____ Pager/Other #: _____

Wk#: (___) _____ Ext: ____ DL#: _____

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: _____

2 Spouse's Information

His/Her Name: _____

Employer: _____

Work #: (___) _____ Ext: ____ SS #: _____

Birthdate: ___/___/___

Person Responsible for Account: _____

Wk#: (___) _____ Ext: ___ Hm#: (___) _____

Billing Address: _____

Relation: _____ SS#: _____

Employer: _____ DL#: _____

3 Insurance

Primary Insurance

Ortho Coverage ☐Yes ☐No Dental Coverage ☐Yes ☐No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co Phone: (___) _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___

Insured's ID# _____

Secondary Insurance

Ortho Coverage ☐Yes ☐No Dental Coverage ☐Yes ☐No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co Phone: (___) _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___

Insured's ID# _____

In the event of an emergency, is there someone who lives near you that we should contact?

Name: _____ Relation: _____

Wk #: (___) _____ Hm#: (___) _____

4 Medical History

Do you have a personal Physician? ☐Yes ☐No

Physician's Name: _____

Phone #: (___) _____ Date of last visit: _____

5 Medical History *continued*

Your current physical health is: ☐ 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: _____

For Women:

Are you pregnant? ☐ Yes ☐ No Week #: _____

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

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

Please List any serious medical condition(s) that you have ever had: _____

Are you allergic to any of the following?

Y N	Aspirin	Y N	Dental Anesthetics	Y N	Penicillin
Y N	Any Metals	Y N	Erythromycin	Y N	Tetracycline
Y N	Codeine	Y N	Latex	Y N	Other

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

6 Dental History

What are the main concerns that you would like orthodontics 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

Have you ever had an injury to your: Mouth Teeth Chin

Do you have any speech problems? _____

Do you generally breathe through your mouth?

If yes, please circle: While awake? While Asleep?

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

Have you ever taken Fosamax? ☐ Yes ☐ No

Have you ever taken Phen-Fen? ☐ Yes ☐ No

Do you smoke or use tobacco in any form? ☐ Yes ☐ No

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 confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature **Date**

Thank you for filling out this form completely.

This office reserves the right to verify the credit status of potential patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office.

Signature **Date**

Signature **Date**

OFFICE USE ONLY

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

Doctor's Comments: **Initials:** _____ **Date:** _____