A REASON TO SMILE

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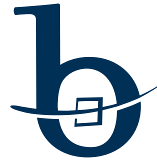

BOVENIZER & BAKER
ORTHODONTICS

Patient Information

NAME ______ PREFERRED NAME ______ M F

DATE OF BIRTH ______ SSN ______

HOME PHONE ______ CELL PHONE ______

ADDRESS ______ EMAIL ______

CITY ______ STATE ______ ZIP ______ HOW LONG AT THIS ADDRESS? ______

EMPLOYER ______ OCCUPATION ______

EMPLOYER ADDRESS ______ CITY ______ STATE ______ ZIP ______

WORK PHONE ______ NUMBER OF YEARS EMPLOYED ______

WHOM MAY WE THANK FOR REFERRING YOU? ______

MARITAL STATUS ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐ SINGLE

Spouse Information

(IF APPLICABLE)

SPOUSE'S NAME ______ DATE OF BIRTH ______ SSN ______

EMPLOYER ______ OCCUPATION ______

EMPLOYER ADDRESS ______ CITY ______ STATE ______ ZIP ______

WORK PHONE ______ NUMBER OF YEARS EMPLOYED ______

CELL PHONE ______ WORK PHONE ______

EMAIL ______

Primary Dental Insurance

☐ CHECK HERE IF NO ORTHODONTIC COVERAGE WILL BE APPLIED

INSURANCE COMPANY ______ INSURANCE PHONE NUMBER ______

EMPLOYER/GROUP NAME ______ GROUP NUMBER ______

SUBSCRIBER/EMPLOYEE ______ SUBSCRIBER ID/SSN ______

DATE OF BIRTH ______ RELATIONSHIP TO PATIENT ______

Secondary Dental Insurance

☐ CHECK HERE IF NO SECONDARY INSURANCE

INSURANCE COMPANY ______ INSURANCE PHONE NUMBER ______

EMPLOYER/GROUP NAME ______ GROUP NUMBER ______

SUBSCRIBER/EMPLOYEE ______ SUBSCRIBER ID/SSN ______

DATE OF BIRTH ______ RELATIONSHIP TO PATIENT ______

Emergency Contact Information

NAME ______ RELATIONSHIP TO PATIENT ______

HOME PHONE ______ CELL PHONE ______

Please take a moment to complete the reverse side of this form.

Medical History

PHYSICIAN ______________________ PHONE ______________________ DATE OF LAST EXAM __________

Y N

1. ARE YOU UNDER MEDICAL TREATMENT NOW? ☐ ☐
2. HAVE YOU BEEN HOSPITALIZED FOR ANY SURGICAL OPERATIONS OR SERIOUS ILLNESS IN THE PAST FIVE YEARS? ☐ ☐

____

____

3. ARE YOU TAKING MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE? ☐ ☐

   IF YES, WHAT MEDICATION(S) ARE YOU TAKING?

   ____

   ____

4. DO YOU USE TOBACCO? ☐ ☐
5. ARE YOU AWARE OF BEING ALLERGIC TO ANY MEDICATIONS OR SUBSTANCE, INCLUDING METALS? ☐ ☐

   IF YES, WHAT?

   ____

   ____

6. FEMALES ONLY: Y N

   ARE YOU PREGNANT, OR THINK YOU MAY BE? ☐ ☐

Y N

7. EVER TAKEN BISPHOSPHONATES (EX: FOSAMAX) FOR OSTEOPOROSIS? ☐ ☐

   IF YES, SPECIFY ______________________

8. PLEASE CHECK ALL THAT APPLY:

HAY FEVER/ALLERGIES	☐	LEUKEMIA	☐
COLD SORES	☐	KIDNEY/LIVER DISEASE	☐
MIGRAINES	☐	ANEMIA	☐
DIABETES/GLAUCOMA	☐	CANCER	☐
RHEUMATIC FEVER	☐	JOINT REPLACEMENT/IMPLANT	☐
AIDS OR HIV INFECTION	☐	HEPATITIS/JAUNDICE	☐
CARDIAC PACEMAKER	☐	STOMACH TROUBLES/ULCERS	☐
ASTHMA (INHALER)	☐	SINUS PROBLEMS	☐
FAINTING/SEIZURES	☐	STROKE	☐
THYROID PROBLEM	☐	RADIATION THERAPY	☐
HIGH/LOW BLOOD PRESSURE	☐	RESPIRATORY PROBLEMS	☐
HEART TROUBLE	☐	BONE DISORDER	☐
EPILEPSY/CONVULSIONS	☐	OSTEOPEMIA/OSTEOPOROSIS	☐
TAKING MEDICATION:	☐	REMOVAL OF ADENOIDS/TONSILS	☐

IF SO, SPECIFY: ______________________

____

Dental History

DENTIST ______________________

DATE OF LAST CLEANING ______________________

Y N

1. ARE YOU ANXIOUS OR NERVOUS ABOUT DENTAL TREATMENT? ☐ ☐
2. DO YOU REQUIRE PREMEDICATION FOR DENTAL TREATMENT? ☐ ☐
3. DO YOU FEEL PAIN TO ANY OF YOUR TEETH? ☐ ☐
4. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH? ☐ ☐
5. HAVE YOU HAD ANY HEAD, NECK, OR JAW INJURIES? ☐ ☐

   IF YES, PLEASE DESCRIBE:

   ____

6. DO YOU HA VE ANY ONGOING PROBLEMS IN YOUR JAW WITH:

   A. CHRONIC CLICKING OR POPPING? ☐ ☐

   B. PAIN? ☐ ☐

   C. DIFFICULTY OPENING OR CLOSING? ☐ ☐

   D. DIFFICULTY IN CHEWING? ☐ ☐

7. DO YOU CLENCH OR GRIND YOUR TEETH? ☐ ☐
8. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY? ☐ ☐
9. HAVE YOU EVER HAD SPEECH THERAPY? ☐ ☐

   IF YES, PLEASE DESCRIBE:

   ____

Y N

10. IS THERE ANY OUTSTANDING DENTAL TREATMENT TO BE COMPLETED? ☐ ☐

    IF YES, PLEASE DESCRIBE:

    ____

11. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING AND FLOSSING YOUR TEETH? ☐ ☐
12. DO YOU HA VE ANY OF THE FOLLOWING ORAL HABITS:

    A. NAIL BITING? ☐ ☐

    B. THUMB SUCKING? ☐ ☐

    C. TONGUE THRUST WHILE SWALLOWING? ☐ ☐

    D. MOUTH BREATHING? ☐ ☐

13. HOW MANY TIMES A DAY DO YOU BRUSH? __________
14. PLEASE CHECK THE BOXES BELOW WHICH DESCRIBE THE PROBLEM(S) FOR WHICH YOU ARE SEEKING TREATMENT:

CROWDING	☐	MISSING TEETH	☐
EXTRA SPACE	☐	EXTRA PERMANENT TEETH	☐
TEETH STICK OUT TOO FAR	☐	TEETH ERUPTING IN THE WRONG POSITION	☐
TMJ PROBLEMS	☐	OTHER: __________	
POOR BITE RELATIONSHIP	☐		

Y N

15. HAS THE PATIENT HAD AN ORTHODONTIC EVALUATION OR TREATMENT BEFORE? ☐ ☐

    IF SO, WHEN AND BY WHOM?

    ____

Authorization and Release

TO THE BEST OF MY KNOWLEDGE THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES TO THE PATIENT'S MEDICAL STATUS. I GIVE BOVENIZER & BAKER ORTHODONTICS PERMISSION TO PERFORM THE NECESSARY DENTAL SERVICES THAT THE PATIENT MAY NEED.

SIGNATURE OF PATIENT ______________________ DATE __________

PRINT NAME ______________________