A REASON TO SMILE

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BOVENIZER & BAKER ORTHODONTICS

Patient Information

NAME _____ PREFERRED NAME _____ M F

SSN _____ DOB _____ GRADE _____ SCHOOL ATTENDS _____

HOME PHONE _____ CELL PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

NAME/RELATIONSHIP OF PERSON ACCOMPANYING PATIENT TO TODAY'S APPOINTMENT _____

PATIENT LIVES WITH WHOM/RELATIONSHIP _____

WHO HAS LEGAL CUSTODY OF PATIENT? _____

NAME OF SIBLINGS & AGES _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

Responsible Party

☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐ SINGLE

MOTHER'S NAME _____ FATHER'S NAME _____

☐ PARENT ☐ GUARDIAN ☐ STEPMOTHER ☐ PARENT ☐ GUARDIAN ☐ STEPFATHER

DATE OF BIRTH _____ SSN _____ DATE OF BIRTH _____ SSN _____

ADDRESS _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____ CITY _____ STATE _____ ZIP _____

HOW LONG AT THIS ADDRESS? _____ HOW LONG AT THIS ADDRESS? _____

CELL PHONE _____ CELL PHONE _____

WORK PHONE _____ WORK PHONE _____

EMPLOYER _____ YEARS EMPLOYED _____ EMPLOYER _____ YEARS EMPLOYED _____

OCCUPATION _____ OCCUPATION _____

EMAIL _____ 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 (OTHER THAN RESPONSIBLE PARTY)

NAME _____ RELATIONSHIP TO PATIENT _____

HOME PHONE _____ CELL PHONE _____

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

PLEASE READ: We are passionate about our mission to give everyone a great smile. Please help us help you and your child by letting us know of any delayed development, social disabilities, ADD or ADHD, Bipolar, Autism, etc. _____

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
A. HAS MENSTRUATION BEGUN? IF YES, DATE: _____	☐	☐
B. ARE YOU PREGNANT, OR THINK YOU MAY BE?	☐	☐
7. EVER TAKEN BISPHOSPHONATES (EX: FOSAMAX) FOR OSTEOPOROSIS?	☐	☐
IF YES, SPECIFY _____		
8. HAS THE PATIENT REACHED PUBERTY?	☐	☐

9. 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 HAVE 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:		
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 HAVE 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	☐		
POOR BITE RELATIONSHIP	☐	OTHER: _____	

	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 (OR PARENT IF MINOR) _____ DATE _____

PRINT NAME _____ RELATIONSHIP TO PATIENT _____