LET'S GET ACQUAINTED

Patient Information

Name ______________________________ I Prefer To Be Called (Nickname) __________
Last First Middle (Maiden)

Sex: M F Birthdate ______________ Age ________ Sports/Hobbies ______________________

Occupation: ______________ Employer ______________________ No. Years Employed ________

Work Phone ( ) ______________ Cell Phone ( ) ______________ Soc. Sec. # ______________

Residence ____
Street City Zip

Mailing Address (If Different) ____
Street City Zip

How Long At This Address ________ Home Phone ( ) ______________ E-Mail ______________

Previous Address (If Less Than 3 Years) ____
Street City State Zip

Any Anticipated Move Or Transfer? ❑ Yes ❑ No When? ____________ Where? ______________

Who May We Thank For Referring You To Us? ____

Dentist ______________________ Oral Surgeon ______________________

Periodontist ______________________ Physician ______________________

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Remarried

Name Of Spouse ______________________________ Birthdate ______________

Spouse's Occupation ______________ Employer ______________________ No. Years Employed ________

Work Phone ( ) ______________ Cell Phone ( ) ______________ Soc. Sec. # ______________

Do You Have Children? ❑ Yes ❑ No Names and Ages ______________________________

Person Responsible For This Account ____

Dental/Orthodontic Insurance Information

Insurance Company ______________________ Group # __________ Local # __________

Insurance Co. Address ______________________ Phone ( ) ______________

Policy Owner's Name ______________________ Birthdate __________ Soc. Sec. # __________

Do You Have Dual Coverage? ❑ Yes ❑ No If Yes, Complete Below:

Insurance Company ______________________ Group # __________ Local # __________

Insurance Co. Address ______________________ Phone ( ) ______________

Policy Owner's Name ______________________ Birthdate __________ Soc. Sec. # __________

Emergency Information

Name Of Nearest Relative Not Living With You ______________________ Relationship __________

Address ____
Street City State Zip

Phone ( ) ______________

(CONTINUED ON BACK)

Medical History

Are You In Good Health? ❑ Yes ❑ No If No, Explain ______

Have You Been Diagnosed Or Treated For Any Of The Following?

Y N AIDS/HIV Virus	Y N Bone Disorders	Y N Epilepsy	Y N High Or Low Blood Pressure
Y N Allergies, Hay Fever, Sinus	Y N Cancer Or Tumor	Y N Fainting Or Dizziness	Y N Stroke
Y N Arthritis	Y N Diabetes	Y N Heart Trouble	Y N Tuberculosis (TB)
Y N Asthma	Y N Emotional	Y N Hepatitis (Jaundice)	Other ______
Y N Prolonged Bleeding	Y N Endocrine (Thyroid)	Y N Herpes	______

Y N Are You Under The Care Of A Physician? If Yes, Explain ______

Y N Have You Had Any Major Illness Or Surgery? If Yes, Explain ______

Y N Are You Taking Any Drugs Or Medications? Taking ______ For ______

Taking ______ For ______ Taking ______ For ______

Y N Have You Ever Taken Any Bisphosphonate (e.g. Fosamax, Boniva, Actonel) To Treat Any Bone Disorders Such As Osteoporosis Or Osteopenia?

Y N Do You Have A History Of Congenital Heart Disease, Infective Endocarditis, Or Surgery To Place Artificial Cardiac Valves?

Y N Have Your Ever Had Surgery For Any Joint (Knee, Hip, Etc.) Replacement (Artificial Joint)?

Y N Have You Ever Been Told That You Need To Take Antibiotics (Premedication) For Dental Treatment Or Teeth Cleaning?

Y N Do You Have Any Drug Sensitivities Or Drug Allergies? Please List ______

Y N Do You Have An Allergy To Latex?

Y N Have You Ever Been Diagnosed Or Treated For Sleep Apnea?

ANY OTHER MEDICAL PROBLEMS THAT I SHOULD BE AWARE OF? ______

For Women: **Y N** Are You Pregnant? Expected Delivery Date ______

Dental History

Date Of Last Dental Check-up ______ Date Of Last Cleaning ______

Date Of Last X-Rays ______ Name Of Dentist ______

Y N Have You Had Any Injuries To Your Face, Mouth, Teeth or Chin? Explain ______

Y N Do You Have Any Problems Breathing Through Your Nose? (Do You Mouth Breathe?) Explain ______

Y N Do You Play A Musical Instrument? List ______

Y N Do You Clench Or Grind Your Teeth? When? ______

Y N Do You Have Any Difficulty In Chewing Or Swallowing? Explain ______

Y N Do You Have Frequent Headaches, Neck Or Shoulder Pain? Explain ______

Y N Do You Have Jaw Joint (TMJ/TMD) Pain Or Noises Upon Opening Or Closing Your Mouth? Explain ______

Y N Have You Been Informed Of Any Jaw Joint (TMJ/TMD) Problem? Explain ______

Y N Have You Been Informed Of Any Existing Or Potential Periodontal (Gum, Bone Loss) Problem? Explain ______

Y N Have You Been Informed Of Any Missing Or Extra Permanent Teeth? Explain ______

Y N Have Your Wisdom Teeth Been Extracted? How Many? ______

Y N Is Any Part Of Your Mouth Sensitive To Temperature, Pressure, Food Or Drink? Explain ______

Y N Do You Smoke Or Use Any Other Tobacco Product? How Much? ______

Y N Has An Orthodontist Been Consulted Previously? Who? ______ When? ______

Y N Have You Been Dissatisfied With Any Previous Dentist Or Orthodontist? Who? ______

Y N Does Any One In Your Family Have A Similar Orthodontic Problem? Who? ______

Y N Are You Dissatisfied With Your Teeth Or Appearance? Explain ______

What Concerns You Most About The Thought Of Orthodontic Treatment? ______

WHAT IS YOUR MAIN REASON FOR SEEKING ORTHODONTIC CARE? ______

I Understand That Appropriate Credit Bureau Reports May Be Obtained.

DATE ______ **YOUR SIGNATURE** ______

SM FORM 12A UPDATE ______ / ______ (SIGN / DATE) UPDATE ______ / ______ (SIGN / DATE) UPDATE ______ / ______ (SIGN / DATE)