GEORGETOWN
ORTHODONTICS

1. ABOUT YOU

Today's Date:_____

Name:_____
Last First M. Ini.

I prefer to be called:_____ ❑ Male ❑ Female

Birthdate: _____/_____/_____ Age:_____

SS#:_____

Home Address:_____

_____
City State Zip

❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ 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:_____

Any Treatment Rendered?_____

2. SPOUSE INFORMATION

His/Her Name:_____

Employer:_____

Wk#:( ) _____ Ext._____

SS#:_____

Birthdate:_____/_____/_____ Age:_____

Person Responsible for Account:_____

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

Billing Address:_____

Relation:_____ SS#:_____

Employer:_____

DL#_____

3. ORTHODONTIC INSURANCE

Orthodontic Coverage? ❑Yes ❑ No

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone#: ( )_____

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

Insured's Name:_____

Relationship to Patient:_____

Insured's Birthdate:_____/_____/_____

Insured's SS#:_____

Insured's Employer:_____

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

His/Her Name:_____ Relation:_____

Wk#:_____ Hm#:_____

4. MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name:_____

Phone #: ( )_____

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 taking birth control pills? ❑ Yes ❑ No

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

Are you nursing? ❑ Yes ❑ No

4. MEDICAL HISTORY *continued*

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

Y N Anemia/Radiation Treatment	Y N Heart Surgery/ Pacemaker
Y N Artificial Bones/Joints	Y N Hemophilia/Abnormal Bleeding
Y N Artificial Valves	Y N Hepatitis
Y N Asthma Arthritis	Y N High/Low Blood Pressure
Y N Blood Transfusion	Y N HIV +/AIDS
Y N Cancer/Chemotherapy	Y N Hospitalized for Any Reason
Y N Congenital Heart Defect	Y N Kidney Problems
Y N Diabetes/Tuberculosis	Y N Mitral Valve Prolapse
Y N Difficulty Breathing	Y N Psychiatric Problems
Y N Drug/Alcohol Abuse	Y N Rheumatic/Scarlet Fever
Y N Emphysema/Glaucoma	Y N Severe/Frequent Headaches
Y N Epilepsy/Seizure/Fainting Spells	Y N Shingles
Y N Fever Blisters/Herpes	Y N Sinus Problems
Y N Heart Attach/Stroke	Y N Ulcers/Colitis
Y N Heart Murmur	Y N Veneral 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 Codeine	Y N Any Metal/Plastic	Y N Latex
Y N Tetracycline	Y N Erythromycin	Y N Other

5. DENTAL HISTORY

What are the main concerns that you would like orthodontics to accomplish?

_____

_____

_____

Have you ever 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

Do you like your smile? ❑ Yes ❑ No

Do your gums bleed? ❑ Yes ❑ No

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

Do you have any speech problems?

_____

Do you generally breathe through your mouth?

Y N Awake? Y N Asleep?

Do you have any missing or extra permanent teeth?

❑ 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 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 and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services

_____

Signature Date

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDA and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

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

Doctor's Comments Initials: _____ Date: _____

_____

_____

_____