WELCOME
TO SCOTT ORTHODONTICS

The benefits of a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset. Please fill out this form completely. The better we communicate, the better we can care for you.

ABOUT YOU

Today's Date_____

Name:_____
LAST FIRST M MR MRS MS DR

I prefer to be called:_____ ❒ Male ❒ Female

Birth Date: ___/___/___ SS#_____

Home Address:_____
APT/CONDO#

_____
CITY STATE ZIP

❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Separated

Hm#:(____)_____Cell#:(____)_____

Wk#:(____)_____Ext#:_____

E-Mail: _____

Employer:_____

Employer's Address:_____

How long there?_____ Occupation:_____

Best place to reach you:_____

Whom may we thank for referring you?_____

_____

Other family members seen by us:_____

General Dentist:_____

Last Visit Date:_____

SPOUSE INFORMATION

His / Her Name:_____

Employer:_____

Wk#:(___)_____Ext:_____SS#_____

Birth Date:_____/_____/_____

PERSON RESPONSIBLE FOR ACCOUNT (If other than self)

His / Her Name:_____

Wk#: (___)_____Ext:____Hm#: (___)_____

Cell#:(___)_____

E-Mail: _____

Billing Address: _____
CITY STATE ZIP

_____

Relation:_____SS#_____

Employer: _____

PRIMARY ORTHODONTIC INSURANCE

Orthodontic Coverage? ❒ Yes ❒ No ❒ Don't Know

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone #: (____)_____

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

Insured's Name:_____

Relationship to Patient:_____

Insured's Birth Date:_____/_____/_____

Insured's ID# or SS#:_____

Insured's Employer:_____

SECONDARY ORTHODONTIC INSURANCE

Orthodontic Coverage? ❒ Yes ❒ No ❒ Don't Know

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone #: (____)_____

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

Insured's Name:_____

Relationship to Patient:_____

Insured's Birth Date:_____/_____/_____

Insured's ID# or 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#: (___)_____

MEDICAL HISTORY

Do you have a personal physician? ❒ Yes ❒ No

Physician's Name:_____

Phone#:(____)_____Date of last visit_____

CONTINUED ON BACK

MEDICAL HISTORY

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 and/or over-the-counter drugs? ❒ Yes ❒ No

Please list each one:_____

_____

Have you ever taken Phen-Phen: ❒ Yes ❒ No

For Women:
Are you taking birth control pills? ❒ Yes ❒ No

Are you pregnant? (If yes, week#____) ❒ Yes ❒ No

Are you nursing? ❒ Yes ❒ No

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 (TB)	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 / Seizures / Fainting Spells	Y N	Shingles
Y N	Fever Blisters ? Herpes	Y N	Sinus Problems
Y N	Heart Attack / Stroke	Y N	Ulcers / Colitis
Y N	Heart Murmur	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 Metal / Plastic	Y N	Erythromycin	Y N	Tetracycline
Y N	Codeine	Y N	Latex	Y N	Other

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

_____

_____

WHAT ARE THE MAIN CONCERNS THAT YOU WOULD LIKE ORTHODONTICS TO ADDRESS?

_____

_____

_____

DENTAL HISTORY

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

Do you like your smile? ❒ Yes ❒ No

Do your gums ever 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? ❒ Yes ❒ No

When awake? ❒ Yes ❒ No When asleep ❒ Yes ❒ No

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

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

OFFICE USE ONLY

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

Doctors' Comments: Initials: _____ Date:_____

_____

_____

_____