MEDINA ORTHODONTICS

## TELL US ABOUT YOURSELF

Today's Date:_____

Preferred Name:_____

Name:_____
Last First MI

E-Mail Address:_____

SS#_____ Birthdate ____/____/____

Age:_____ ☐ Male ☐ Female

Hobbies/Sports:_____

Home#: (_____)_____

Cell#: (_____)_____

Address: _____

_____
City State Zip

## PRIMARY ORTHODONTIC INSURANCE

Orthodontic Coverage: ☐ Yes ☐ No

Insurance Co. Name:_____

Insurance Co. Address:_____

_____
City State Zip

Insurance Co. Phone #: (_____)_____

Policy Owner's Name:_____

Relationship to Patient:_____

Policy Owner's Birthdate: _____/_____/_____

SS#:_____

Policy Owner's Employer:_____

Employer's Address: _____

_____
City State Zip

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

Has any of your orthodontic maximum been used for Orthodontic treatment? ☐ Yes ☐ No

## PERSON RESPONSIBLE FOR ACCOUNT

Name:_____ Relation:_____

Billing Address:_____

_____
City State Zip

Hm#: (_____)_____ Cell#: (_____)_____

Wk#: (_____)_____ Ext:_____

DL#:_____ SS#:_____

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

_____

Have you Ever taken Phen-Fen? (also known as Redux or Pondimin) ☐ Yes ☐ No

Have your ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No

Have you had any injuries to the face, mouth, teeth or chin? ☐ Yes ☐ No

List any musical instrument played:_____

Have adenoids or tonsils been removed? ☐ Yes ☐ No

Have you been informed of any missing or extra permanent teeth? ☐ Yes ☐ No

Have you had any pain/tenderness in your jaw joint (TMJ/JMD)? ☐ Yes ☐ No

Do your brush your teeth daily? ☐ Yes ☐ No

Floss your teeth daily? ☐ Yes ☐ No

Physician's Name:_____

Phone#: (____)_____ Date of last visit _____

Are you under the care of a physician? ☐ Yes ☐ No

Please describe your current physical health:

☐ Good ☐ Fair ☐ Poor

Please list all drugs you are currently taking:

_____

Please list all drugs/things you are allergic to:

_____

## HAVE YOU HAD ANY OF THE FOLLOWING PROBLEMS?

Y N Abnormal Bleeding
Y N ADD/ADHD
Y N Allergies to drugs
Y N Allergies to latex
Y N Hearing Impairment
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis
Y N Asthma
Y N Cancer
Y N Congenital Heart Defect
Y N Artificial Bones/Joints/Valves
Y N Rheumatic/Scarlet Fever
Y N Convulsions/Epilepsy
Y N Diabetes
Y N Handicaps/Disabilities
Y N Allergies to metal
Y N Allergic to Plastic
Y N Any Hospital Stays
Y N Any Operations
Y N HIV/AIDS
Y N Kidney/Liver Problems
Y N Tuberculosis (TB)

## Please discuss any medical problems you have had:

_____

_____

_____

## HAVE YOU HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

Y N Nursing Bottle Habits
Y N Speech Problems
Y N Nail Biting
Y N Thumb/Finger Sucking
Y N Clenching/Grinding Teeth
Y N Lip Sucking/Biting
Y N Mouth Breather
Y N Tongue Thrust

## NEIGHBOR OR RELATIVE NOT LIVING WITH YOU.

NAME: _____ Phone: (___)_____

Address: _____

_____
City State Zip

- **I understand that the information that I have given Is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.**

- **This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fee and may, at the discretion of one or more credit reporting services.**

- **I authorize the dental staff to perform any necessary dental services I may need.**

**If this office accepts insurance, I understand that I am Responsible for payments of services rendered and also Responsible for paying any co-payment and deductibles that my insurance does not cover.**

_____
**Signature** **Date**

*I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.*

**The Parent or Guardian who accompanies this child is responsible for payment. Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and ADA.**