

Certified, American Board of Orthodontics

Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you!

<u>PATIENT INFORMATION</u>	<u>REFERRAL</u>
Name Date	WHO REFERRED YOU TO OUR OFFICE?
Nickname	
Birthdate Age	
Address	☐ Friend
CityStateZipcode	☐ Yellow Pages
Previous address (if less than 3 years)	Other
Home PhoneWk #	SPOUSE'S INFORMATION
Cell Phone# Marital Status \(\sigma \) S \(\sigma \) M \(\sigma \) D	Nama Distribution ()
SSN	Name Birthdate/
Employer	Address
Job titleNo. of years employed	CityStateZipcode
Dentist Last Visit	City State Zipcode
Favorite Sports or Hobbies	Home# Wk #
Other	Employer Job title
In case of an Emergency Contact	Zimproyet
Phone #Relation	No. of years employed Marital Status
INSURANCE INFORMATION ☐ YES ☐ NO Primary Insurance Company	SSN
Subscriber Name	PERSON FINANCIALLY RESPONSIBLE
Birthdate/SSN	No.
Subscriber # Group #	Name Relation
Insurance phone #	FOR OFFICE USE ONLY
Secondary Insurance Name	
Subscriber Name	Primary
Birthdate/ SSN	Coverage Amount % up to max ded
Subscriber # Group #	
Insurance phone #	Secondary
Check out our website at www.webracem.com	Coverage Amount% up to max ded
Please complete the Dental and Medic	al History on the back page. Thank you!

Have you had any previous orthodontic treatment or consultation?	In your words, what is the orthodontic problem?			
Has any other family member had orthodontics?	Have you had any previous orthodontic treatment of	or consultation?		
Were the results acceptable? Do you now have or have you ever experienced pain or discomfort in your jaw joint? Do you grind your teeth? Do you have any speech problems? Do you have any speech problems? Do you have or have you ever had any thumb of finger sucking habits? Do you have or have you ever had any thumb of finger sucking habits? Do you usually breath through your mouth while awake? Have you ever experienced an adverse reaction during a medical or dental procedure? Have you ever experienced an adverse reaction during a medical or dental procedure? Have you ever received serious trauma or injury to the teeth, face, jaws, or head? Will you best describe the patients attitude toward orthodontic treatment: MEDICAL HISTORY Do you have, or have you ever had: Diabetes MEDICAL HISTORY Do you have, or have you ever had: Diabetes MEDICAL HISTORY Do you have, or have you ever had: Diabetes Are you under the care of a physician for a specific condition? Yes No If yes, please describe Are you taking any medications? Yes No If yes, please fist Please check if you had any of the following: AIDS/HIV Positive Difficulty Breathing Rheumatic/Scarlet Fever Asthma or Hayfever Difficulty Breathing Rheumatic/Scarlet Fever Headaches Difficulty Breathing Rheumatic/Scarlet Fever Headaches Tuberculosis AUTHORIZATION Lunderstand and acknowledge that I am financially responsible for the service provided for myself or the above named, regardless of insurance coverage. Treatment plans involving extended credit circumstances may have a credit check done on my credit rating. I also understand that the testiment estimate presented to me is only an estimate. In the reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the orthodonists to help determine appropriate and helpful orthodonic testiment. If there is any change in my dental or medical status, I will inform Dr. John.	If so, what work was completed, and by whom?			
Will you best describe the patients attitude toward orthodontic treatment: Wants treatment Treatment is necessary Unwilling, but agrees Uncooperative	Has any other family member had orthodontics?			
Do you now have or have you ever experienced pain or discomfort in your jaw joint?	If so, what work was completed and by whom?			
Do you grind your teeth?	Were the results acceptable?		☐ Yes ☐ No	
Do you have any speech problems?	Do you now have or have you ever experienced pain or discomfort in your jaw joint?		☐ Yes ☐ No	
Do you have or have you ever had any thumb of finger sucking habits?	Do you grind your teeth?		☐ Yes ☐ No	
Do you usually breath through your mouth while awake? Yes No Have you ever experienced an adverse reaction during a medical or dental procedure? Yes No Have you ever received serious trauma or injury to the teeth, face, jaws, or head? Yes No Will you best describe the patients attitude toward orthodontic treatment: Wants treatment Treatment is necessary Unwilling, but agrees Uncooperative	Do you have any speech problems?		☐ Yes ☐ No	
Have you ever experienced an adverse reaction during a medical or dental procedure?	Do you have or have you ever had any thumb of finger sucking habits?		☐ Yes ☐ No	
Have you ever received serious trauma or injury to the teeth, face, jaws, or head?	Do you usually breath through your mouth while awake?		☐ Yes ☐ No	
Will you best describe the patients attitude toward orthodontic treatment: Wants treatment Treatment is necessary Unwilling, but agrees Uncooperative	Have you ever experienced an adverse reaction during a medical or dental procedure?		☐ Yes ☐ No	
Wants treatment Treatment is necessary Unwilling, but agrees Uncooperative	Have you ever received serious trauma or injury to the teeth, face, jaws, or head?		☐ Yes ☐ No	
MEDICAL HISTORY Do you have, or have you ever had:	Will you best describe the patients attitude toward	orthodontic treatment:		
Do you have, or have you ever had:	☐ Wants treatment ☐ Treatment	is necessary	es • Uncooperative	
Are you under the care of a physician for a specific condition?	М	EDICAL HISTORY		
If yes, please describe		EDIC/ID HISTORI		
Are you taking any medications?			tificial joints or heart valves	
Please check if you had any of the following: AIDS/HIV Positive Difficulty Breathing Rheumatic/Scarlet Fever Asthma or Hayfever Endocrine or Growth Problems Tonsilitis Blood Pressure Problems Headaches AUTHORIZATION I understand and acknowledge that I am financially responsible for the service provided for myself or the above named, regardless of insurance coverage. Treatment plans involving extended credit circumstances may have a credit check done on my credit rating. I also understand that the treatment estimate presented to me is only an estimate. I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the orthodontist to help determine appropriate and helpful orthodontic treatment. If there is any change in my dental or medical status, I will inform Dr. John.	Do you have, or have you ever had:	es	·	
Please check if you had any of the following: AIDS/HIV Positive Difficulty Breathing Rheumatic/Scarlet Fever Asthma or Hayfever Endocrine or Growth Problems Tonsilitis Headaches Tuberculosis AUTHORIZATION I understand and acknowledge that I am financially responsible for the service provided for myself or the above named, regardless of insurance coverage. Treatment plans involving extended credit circumstances may have a credit check done on my credit rating. I also understand that the treatment estimate presented to me is only an estimate. I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the orthodontist to help determine appropriate and helpful orthodontic treatment. If there is any change in my dental or medical status, I will inform Dr. John.	Do you have, or have you ever had: Diabeted Are you under the care of a physician for a specific	es	·	
Allergies	Do you have, or have you ever had: Diabete Are you under the care of a physician for a specific If yes, please describe	es	·	
Asthma or Hayfever	Do you have, or have you ever had:	es	·	
Blood Pressure Problems Headaches Tuberculosis AUTHORIZATION I understand and acknowledge that I am financially responsible for the service provided for myself or the above named, regardless of insurance coverage. Treatment plans involving extended credit circumstances may have a credit check done on my credit rating. I also understand that the treatment estimate presented to me is only an estimate. I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the orthodontist to help determine appropriate and helpful orthodontic treatment. If there is any change in my dental or medical status, I will inform Dr. John.	Do you have, or have you ever had: Are you under the care of a physician for a specific If yes, please describe Are you taking any medications? Yes If yes, please list Please check if you had any of the following:	es		
AUTHORIZATION I understand and acknowledge that I am financially responsible for the service provided for myself or the above named, regardless of insurance coverage. Treatment plans involving extended credit circumstances may have a credit check done on my credit rating. I also understand that the treatment estimate presented to me is only an estimate. I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the orthodontist to help determine appropriate and helpful orthodontic treatment. If there is any change in my dental or medical status, I will inform Dr. John.	Do you have, or have you ever had: Diabeted Are you under the care of a physician for a specific of the speci	es	☐ Hepatitus	
I understand and acknowledge that I am financially responsible for the service provided for myself or the above named, regardless of insurance coverage. Treatment plans involving extended credit circumstances may have a credit check done on my credit rating. I also understand that the treatment estimate presented to me is only an estimate. I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the orthodontist to help determine appropriate and helpful orthodontic treatment. If there is any change in my dental or medical status, I will inform Dr. John.	Do you have, or have you ever had: Are you under the care of a physician for a specific of the specific of th	es	☐ Hepatitus ☐ Rheumatic/Scarlet Fever	
SignatureDate	Do you have, or have you ever had: Are you under the care of a physician for a specific of the specific of th	es	☐ Hepatitus ☐ Rheumatic/Scarlet Fever ☐ Tonsilitis	
	Do you have, or have you ever had: Are you under the care of a physician for a specific of the year of the graph of the following: Are you taking any medications? Yes If yes, please list Please check if you had any of the following: AIDS/HIV Positive Allergies Asthma or Hayfever Blood Pressure Problems I understand and acknowledge that I am financially respective to the plans involving extended credit circulation that is a stimate. I have reviewed the information on this questionnaire, a will be used by the orthodontist to help determine approximate.	es	☐ Hepatitus ☐ Rheumatic/Scarlet Fever ☐ Tonsilitis ☐ Tuberculosis ve named, regardless of insurance lit rating. I also understand that the	