



SMILE ART ORTHODONTICS

New Patient Information (ADULT)

Welcome! Please assist us in your treatment by filling this form out accurately and completely. Thank you.

About You

Your Name (Last, First, MI): _____ Today's Date: _____
Preferred name: _____
Birth date: _____ Age: _____ Gender: Male Female
Home address: _____
Tel #: Home: _____ Work: _____ Cell: _____
Which should we use as the primary contact no.? _____
Email: _____
Occupation: _____ Employer: _____
Marital Status: Single Married Other
If married, Spouse's name: _____ Occupation: _____
Whom may we thank for referring you? _____

Emergency contact

Name: _____ Relation: _____
Tel #: Home: _____ Work: _____ Cell: _____

Medical History

Physician's Name, City and State: _____
Phone #: _____ Approximate date of last visit: _____
Are you currently under the care of a physician? Yes No
If yes, please explain: _____
Are you taking any prescription/over-the-counter drugs? Yes No
If yes, please specify and explain reason: _____
Do you have a history of any major illness/hospitalization? Yes No
If yes, please explain: _____
Do you use any tobacco products? Yes No If yes, what and how often? _____

For women: Are you pregnant? Yes No If yes, Week #: _____
Are you nursing? Yes No Are you taking birth control pills? Yes No

Name (Last, First, MI): _____

Do you have / have you ever had / been treated for any of the following? Please select all that apply:

- | | | |
|--|--|---|
| <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Latex allergy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy/seizures/convulsions | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Fainting/dizziness | <input type="checkbox"/> Psychiatric problems |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Radiation treatment |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing loss/impairment | <input type="checkbox"/> Rheumatic/Scarlet fever |
| <input type="checkbox"/> Auto-immune disease | <input type="checkbox"/> Heart attack/stroke | <input type="checkbox"/> Severe/frequent headaches |
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Cancer/chemotherapy | <input type="checkbox"/> Heart surgery/pacemaker | <input type="checkbox"/> Sickle cell disease/traits |
| <input type="checkbox"/> Canker sores/oral aphthous ulcers | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Cold sores/fever blisters/oral herpes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Congenital heart defect | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV+/Aids | <input type="checkbox"/> Ulcers/Colitis |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Hospitalized for any reason | |
| <input type="checkbox"/> Drug/alcohol abuse | <input type="checkbox"/> Kidney problems | |

Details: _____

Please list any drugs/materials that you are allergic to: _____

Dental History

General dentist: _____

Tel#: _____ Approximate date of last visit: _____

Chief concern: _____

- | | | | | |
|---|--------------------------------------|---------------------------------------|-------------------------------|-------------------------------|
| Have you ever had or been evaluated for orthodontic treatment? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| Have you ever had a serious/difficult problem with any previous dental work? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| Do you have or have you ever had pain/discomfort in your jaw joint (TMJ/TMD)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| Do you like your smile? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| Do your gums bleed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| Have you ever had injury to your (check all applicable): | <input type="checkbox"/> Mouth | <input type="checkbox"/> Teeth | <input type="checkbox"/> Chin | <input type="checkbox"/> Face |
| Do you have any speech problems? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| Do you generally breathe through your mouth? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| If yes, please select applicable: | <input type="checkbox"/> While awake | <input type="checkbox"/> While asleep | | |
| Do you have any missing or extra permanent teeth to your knowledge? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| Do you clench/grind your teeth? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |

Name (Last, First, MI): _____

INSURANCE INFORMATION

Please take care in filling out the required insurance information accurately in order to facilitate efficient billing and claims processing. If you have an insurance card, please bring it with you for the first visit. Thanks!

Primary Insurance

Orthodontic Coverage: Yes No Don't know Dental Coverage: Yes No Don't know

Subscriber's name: _____ Subscriber's birthdate: _____

Subscriber's Employer: _____ Group #: _____

Insurance co. name: _____

Insurance co. phone #: _____

Subscriber's SS#: _____ ID# / Policy#: _____

Secondary Insurance

Orthodontic Coverage: Yes No Don't know Dental Coverage: Yes No Don't know

Subscriber's name: _____ Subscriber's birthdate: _____

Subscriber's Employer: _____ Group #: _____

Insurance co. name: _____

Insurance co. phone #: _____

Subscriber's SS#: _____ ID# / Policy #: _____

I hereby authorize payment of orthodontic benefits otherwise payable to me, directly to the office of Dr. Monica Teredesai. I understand that it is my responsibility to inform this office if there are any changes in my insurance information/coverage.

Subscriber's Signature

Date

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 and/or dental health status.

Signature

Date

For Office Use Only

I verbally reviewed the medical/dental information above with the patient named herein. Initials: _____ Date: _____