

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

Name (Last, First, MI): _____ Date (mm/dd/yy): _____

I prefer to be called: _____

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 Divorced Separated Widowed

Spouse's name: _____ Tel#: Work: _____ Cell: _____

Who is financially responsible for the account?: _____

Any other family members seen at our office?: _____

Whom may we thank for referring you? _____

General dentist: _____

Tel#: _____ Approximate date of last visit: _____

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

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

Dental History

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

Primary Insurance

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

Subscriber's name: _____ Relationship to patient: _____

Subscriber's birthdate: _____ Subscriber's SS#: _____

Policy #: _____ Group #: _____

Subscriber's employer name: _____

Subscriber's employer address: _____

Insurance co. name: _____

Insurance co. address: _____

Insurance co. phone #: _____

Secondary Insurance

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

Subscriber's name: _____ Relationship to patient: _____

Subscriber's birthdate: _____ Subscriber's SS#: _____

Policy #: _____ Group #: _____

Subscriber's employer name: _____

Subscriber's employer address: _____

Insurance co. name: _____

Insurance co. address: _____

Insurance co. phone #: _____

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

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.

Signature

Date

For Office Use Only

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