BasilOrthodontics
Specialist for Children & Adults

1. ABOUT YOU

Today's Date:____________________

Name:____
Last First M. Ini.

I prefer to be called:______________ ❑ Male ❑ Female

Birthdate: ______/_______/_________ Age:________

SS#:____

Home Address:_______________________________

____
City State Zip

❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

Hm#:________________ Pager/Other#_____________

Wk#:______________________ Ext:_____________

Email:______________________________________

Employer:___________________________________

Employer's Address:__________________________

How long there?__________ Occupation:_____________

Where & when are best times to reach you?____________

____
_

Whom may we Thank for referring you?______________

Other family members seen by us?________________

General Dentist:_____________________________

Last Visit Date:______________________________

Any Treatment Rendered?_______________________

2. SPOUSE INFORMATION

His/Her Name:_______________________________

Employer:___________________________________

Wk#:( ) _____________________ Ext.___________

SS#:____

Birthdate:_______/_______/________ Age:__________

Person Responsible for Account:___________________

Wk#:( ) ____________ Ext._____ Hm#:( )_________

Billing Address:______________________________

Relation:_________________ SS#:_______________

Employer:___________________________________

3. ORTHODONTIC INSURANCE

Orthodontic Coverage? ❑Yes ❑ No

Insurance Co. Name:__________________________

Insurance Co. Address:________________________

Insurance Co. Phone#: ( )______________________

Group# (Plan, local, or Policy #):________________

Insured's Name:______________________________

Relationship to Patient:________________________

Insured's Birthdate:_______/_______/___________

Insured's 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#:___________________

4. MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name:_____________________________

Phone #: ( )_________________________________

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/over the counter drugs?

❑ Yes ❑ No

Please list each one:__________________________

For women:

Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Week #:________

Are you nursing? ❑ Yes ❑ No

4. MEDICAL HISTORY *continued*

Have you ever had any of the following diseases or medical problems?

Y N Anemia/Radiation Treatment
Y N Artificial Bones/Joints
Y N Artificial Valves
Y N Asthma Arthritis
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Congenital Heart Defect
Y N Diabetes/Tuberculosis
Y N Difficulty Breathing
Y N Drug/Alcohol Abuse
Y N Emphysema/Glaucoma
Y N Epilepsy/Seizure/Fainting Spells
Y N Fever Blisters/Herpes
Y N Heart Attach/Stroke
Y N Heart Murmur
Y N Heart Surgery/ Pacemaker
Y N Hemophilia/Abnormal Bleeding
Y N Hepatitis
Y N High/Low Blood Pressure
Y N HIV +/AIDS
Y N Hospitalized for Any Reason
Y N Kidney Problems
Y N Mitral Valve Prolapse
Y N Psychiatric Problems
Y N Rheumatic/Scarlet Fever
Y N Severe/Frequent Headaches
Y N Shingles
Y N Sinus Problems
Y N Ulcers/Colitis
Y N Veneral 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 Codeine   Y N Any Metal/Plastic   Y N Latex

5. DENTAL HISTORY

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

____
____
____

Have you ever 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 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?
Y N Awake? Y N Asleep?

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.

____

Thank you for filling out this form completely

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

____
Signature Date

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

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

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

Doctor's Comments Initials: __________ Date: __________

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