Patient Information

Date:_____

Patient's Name:_____ Patient's Date of Birth:_____

Patient's Address:_____

_____

Contact Phone: _____H C W Alternate Phone :_____H C W

Responsible Party #1 (if patient is under 18)

Name:_____ Date of Birth:_____

Relationship to Patient:_____

Address:_____ ___Check Here if Same as Above

_____

Contact Phone:_____ H C W

Contact e-mail:_____

Responsible Party #2

Name:_____ Date of Birth:_____

Relationship to Patient:_____

Address:_____ ___Check Here if Same as Above

_____

Contact Phone:_____ H C W

Contact e-mail:_____

Signature:_____ Date:_____

Blue
ORTHODONTICS
Orthodontics for Children and Adults
Dan Blue, D.D.S., M.S., P.C.

Patient Name: _____

Date of Birth: _____

Medical History

Do you have a physician? Y N
Physician's Name _____
Phone # _____
Are you currently under the care of a physician? Y N
If yes, please explain: _____

Do you smoke or use tobacco? Y N
Do you have any metal rods, pins, or implants? Y N
Are you taking prescription drugs? Y N
For women: Are you taking birth control pills? Y N
Are you pregnant? Y N Nursing? Y N

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

Y N Abnormal Bleeding/Hemophilia
Y N AIDS / HIV
Y N Alcohol / Drug Abuse
Y N Artificial Joints or Valves
Y N Asthma
Y N Diabetes
Y N Epilepsy / Seizure Disorder
Y N Fainting Spells
Y N Congenital Heart Defects
Y N Heart Attack / Surgery
Y N Heart Murmur
Y N Hepatitis
Y N High / Low Blood Pressure
Y N Previous Hospitalization
Y N Kidney Problems
Y N Liver Disease
Y N Mitral Valve Prolapse
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Sickle Cell Disease
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis
Y N Venereal Disease

Please list any other past or present medical conditions:

_____

_____

Medication Allergies:

Dental History

What are your main concerns that you would like for orthodontics to accomplish? _____

_____

_____

Have you ever been evaluated for orthodontic treatment? Y N
Have you had difficulties with previous dental work Y N
Do you have jaw pain / Discomfort (TMJ / TMD) Y N
Your current dental health is : Good Fair Poor
Do you still have wisdom teeth? Y N
Have you injured your Mouth Teeth Chin (please circle)
Do you have speech problems? Y N
Do you usually breath through your mouth?
If yes, please circle While Awake While Asleep
Do you have missing or extra permanent teeth? Y N
Are you happy with the way your smile looks? Y N
If no, then what would you like to change?

_____

_____

_____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any dental / orthodontic services that I / my child may need.

_____

Patient / Parent Signature Date

Our office is HIPPA compliant and committed to meeting and exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA

Dental Insurance Information

Primary Insurance

Insured's Name:_____ Insured's Date of Birth:_____

Insurance Company:_____ Group #_____

Insured's SS# or ID#:_____

Insurance Company Phone #:_____

Employer_____

Insured's Relationship to Patient:_____

Secondary Insurance

Insured's Name:_____ Insured's Date of Birth:_____

Insurance Company:_____ Group #_____

Insured's SS# or ID#:_____

Insurance Company Phone #:_____

Employer_____

Insured's Relationship to Patient:_____

Dentist's Information

Who is your family dentist?_____

Last Cleaning and Checkup Date:_____

Who can we thank for referring you to Blue Orthodontics?_____

What would you like to change about your teeth and smile?_____

_____