Othman ORTHODONTICS & Facial Aesthetics

About You

Today's Date: / /

Name: (First Middle Last)

Birthdate: / / Age: SS#:

Home Address:

(City State Zip)

Single Married Divorced Widowed Separated

Hm#: ( ) Cell#: ( )

Wk#: ( ) DL#: ( )

E-mail Address:

Employer:

Employer's Address:

(City State Zip)

How long there? Occupation:

What time is best to reach you?

Whom may we thank for referring you?

Other family members seen by us:

Dentist Name:

Date of last visit

Ph #: ( )

Person Responsible for Account:

Spouse Information

His / Her Name: (First Middle Last)

Employer:

Wk#: ( ) SS#:

Birthdate: / / DL#: ( )

Relative or friend not living with you:

Name: (First Middle Last)

Relation:

Wk#: ( ) Hm#: ( )

Orthodontics Insurance

Primary

Orthodontic Coverage? Y N Dental Coverage? Y N

Insurance Co. Name:

Insurance Co. Address:

(City State Zip)

Insurance Co. Phone # : ( )

Group # (Plan, Local or Policy #):

Insured's Name:

Relation: Birthdate: / /

Insured's ID / SS#:

Insured's Employer:

Employer's Address:

(City State Zip)

Secondary

Orthodontic Coverage? Y N Dental Coverage? Y N

Insurance Co. Name:

Insurance Co. Address:

(City State Zip)

Insurance Co. Phone # : ( )

Group # (Plan, Local or Policy #):

Insured's Name:

Relation: Birthdate: / /

Insured's ID / SS#:

Insured's Employer:

Employer's Address:

(City State Zip)

Payment is due in full at the time of treatment unless prior arrangements have been approved

I understand that I am responsible for payment of services rendered and for paying any copayment that my insurance does not cover including the deductive. I hereby authorize payment of the group insurance benefit (otherwise payable to me) directly to this office. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature: Date: / /

Medical History

Do you have a personal physician? ☐ Y ☐ N

Physician's Name:

Ph#: ( ) Date of last visit: / /

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Please explain:

Do you smoke or use tobacco in any other form? ☐ Y ☐ N

Have you had any metal rods, pins or implants? ☐ Y ☐ N

Are you taking any prescription/over-the-counter drugs? ☐ Y ☐ N

Please list each one:

Have you ever taken Fosamax or any biphosphonate? ☐ Y ☐ N

Have you ever taken Phen-Fen (Redux or Pondimin)? ☐ Y ☐ N

If so, when?

Women: Are you taking birth control pills? ☐ Y ☐ N

Are you pregnant? ☐ Y ☐ N

Week # Are you nursing? ☐ Y ☐ N

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

Abnormal Bleeding/Hemophilia	☐Y☐N	HIV	☐Y☐N
AIDS	☐Y☐N	Fainting Spells	☐Y☐N
Alcohol / Drug Abuse	☐Y☐N	Frequent Headaches	☐Y☐N
Anemia	☐Y☐N	Glaucoma	☐Y☐N
Arthritis	☐Y☐N	Hay Fever	☐Y☐N
Artificial Bones/Joints / Valves	☐Y☐N	Heart Attack / Surgery	☐Y☐N
Asthma	☐Y☐N	Heart Murmur	☐Y☐N
Blood Transfusion	☐Y☐N	Hepatitis	☐Y☐N
Cancer / Chemotherapy	☐Y☐N	Hospitalized for any Reason	☐Y☐N
Colitis	☐Y☐N	Kidney Problems	☐Y☐N
Congenital Heart Defect	☐Y☐N	Liver Disease	☐Y☐N
Diabetes	☐Y☐N	Low Blood Pressure	☐Y☐N
Difficulty Breathing	☐Y☐N	Epilepsy	☐Y☐N
Emphysema	☐Y☐N	Ulcers	☐Y☐N
Lupus	☐Y☐N	Shingles	☐Y☐N
Mitral Valve Prolapse	☐Y☐N	Sickle Cell Disease / Traits	☐Y☐N
Pacemaker	☐Y☐N	Sinus Problems	☐Y☐N
Psychiatric Problems	☐Y☐N	Stroke	☐Y☐N
Radiation Treatment	☐Y☐N	Venereal Disease	☐Y☐N
Rheumatic / Scarlet Fever	☐Y☐N	Thyroid Problems	☐Y☐N
Tuberculosis (TB)	☐Y☐N	Seizures	☐Y☐N

Please list any serious medical condition (s) that you have ever had:

Are you allergic to any of the following:

Aspirin	☐Y☐N	Erythromycin	☐Y☐N	Penicillin	☐Y☐N
Codeine	☐Y☐N	Jewelry / Metals	☐Y☐N	Tetracycline	☐Y☐N
Dental Anesthetics	☐Y☐N	Latex	☐Y☐N	Other	☐Y☐N

List any other drugs / material allergies:

Dental History

What would you like orthodontics to accomplish?

Have you ever had or been evaluated for orthodontic treatment? ☐ Y ☐ N

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Y ☐ N

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Y ☐ N

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Do you still have wisdom teeth? ☐ Y ☐ N

Have you ever had any injury to your: ☐ Mouth ☐ Teeth ☐ Chin

Have you ever had any speech problems? ☐ Y ☐ N

Do you breathe through your mouth? ☐ While Awake ☐ While Asleep

Do you have any missing or extra permanent teeth? ☐ Y ☐ N

Do you like your smile? ☐ Y ☐ N

If not, what would you change?

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

Signature:

Date: / /

Office Use Only

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

Initials:

Date: / /

Doctor's Comments:

Signature:

Date: / /

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