Payson Orthodontics

WELCOME TO OUR OFFICE

So that we might become better acquainted, please complete both sides of this form.

ADULT PATIENT INFORMATION

Patient's Name _____ Prefer to be called _____ Sex_____

Mailing Address_____ City _____ Zip_____

Home Phone_____ Email _____ Birth date_____

Patient's Dentist _____ Phone Number_____

How did you hear about our office? _____

Who noticed the orthodontic problem? [ ] Patient [ ] Dentist [ ] Other_____

Describe the orthodontic problem in your own words _____

What concerns you most about the thought of orthodontic treatment?

[ ] appearance in appliances [ ] cost [ ] length of time [ ] discomfort [ ] results [ ] other _____

Occupation _____ Employer _____

Address _____ Work Phone _____

FAMILY AND ACCOUNT INFORMATION

Spouse's Name _____ Employer _____Wk Phone_____

Person responsible for account _____

If other than self or spouse:

Name _____ Occupation _____

Address _____ City _____ Zip _____

Home Phone_____ Work Phone_____

INSURANCE INFORMATION

A dental insurance policy is a contract between the insured and the insurance company. Our professional services are rendered and charged directly to the patient's account and ***the patient or person responsible for the account is responsible for payment of all fees incurred.*** For your convenience, we will gladly assist you in submitting insurance claims pertaining to any charge for care in our office. If you wish assistance, we ask that you provide us with a claim form from your insurance carrier on your first visit or as soon as possible. Otherwise we will assume you are submitting all claims to your insurance carrier and the fees will be due in full from you at time of service or billing.

Primary Insurance

Name of insured (Employee) _____ ID#_____ DOB_____

Insurance Co._____Group # _____Ins. Phone # _____

Employer_____

Secondary Insurance

Name of insured (Employee) _____ ID#_____ DOB_____

Insurance Co._____Group # _____Ins. Phone # _____

Employer_____

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your dental care. All information will be kept completely confidential.

MEDICAL HISTORY

Physician's Name_____Phone_____

Have you experienced any health problems? [ ] No [ ] Yes Explain:_____
Any major change in your health recently? [ ] No [ ] Yes Explain:_____
Are you currently under physician's care? [ ] No [ ] Yes Explain:_____
Are you currently taking medications? [ ] No [ ] Yes List:_____
Are you allergic to any medications? [ ] No [ ] Yes List:_____
Are you allergic to latex or metals? [ ] No [ ] Yes List:_____
Have you received a blood transfusion? [ ] No [ ] Yes Reason:_____
Have your tonsils or adenoids been removed? [ ] No [ ] Yes When:_____
Have you been in a risk group for AIDS? [ ] No [ ] Yes Explain:_____

Heart Murmur	[ ] No [ ] Yes	Hepatitis	[ ] No [ ] Yes	Emotional Problems	[ ] No [ ] Yes
Heart Surgery	[ ] No [ ] Yes	Diabetes	[ ] No [ ] Yes	Frequent Headaches	[ ] No [ ] Yes
Rheumatic Fever	[ ] No [ ] Yes	Kidney Disease	[ ] No [ ] Yes	Nervous/Anxious	[ ] No [ ] Yes
Endocrine Disorders	[ ] No [ ] Yes	Liver Disease	[ ] No [ ] Yes	Cancer	[ ] No [ ] Yes
Prolonged Bleeding	[ ] No [ ] Yes	Tuberculosis	[ ] No [ ] Yes	Bone Disorders	[ ] No [ ] Yes
Anemia	[ ] No [ ] Yes	Bronchitis	[ ] No [ ] Yes	Growth Disorders	[ ] No [ ] yes
Blood Disease	[ ] No [ ] Yes	Asthma	[ ] No [ ] Yes	AIDS	[ ] No [ ] Yes
Developmental Disorder	[ ] No [ ] Yes	Epilepsy	[ ] No [ ] Yes	Herpes(fever blisters)	[ ] No [ ] Yes
Hives/Rash	[ ] No [ ] Yes	Fainting	[ ] No [ ] Yes	Tonsillitis	[ ] No [ ] Yes

Is there any other condition or problem that you think we should know about?_____
Comments:_____

DENTAL HISTORY

Dentist's Name:_____
Address_____ **City:**_____ **State**____ **Zip**_____ **Phone**_____

Frequency of dental checkups: Twice a year [ ] Once a year [ ] Only if a problem exist [ ] Never [ ] Date of last visit_____
Is there any unfinished care to be completed with your dentist? [ ] No [ ] Yes Explain:_____
Are you frightened about dental treatment? [ ] No [ ] Yes Explain:_____
Have you had an unpleasant experience in a dental office? [ ] No [ ] Yes Explain:_____
Have you had any face or dental injuries? [ ] No [ ] Yes Explain:_____
Do you play any musical instruments? [ ] No [ ] Yes What instrument?_____
Have you consulted an orthodontist previously? [ ] No [ ] Yes Whom?_____
Have teeth (either primary or permanent) been removed? [ ] No [ ] Yes
Have you had any previous orthodontic treatment? [ ] No [ ] Yes With whom?_____
Are you satisfied with prior treatment? [ ] No [ ] Yes Explain:_____
Have you noticed any changes in your bite or dental alignment recently? [ ] No [ ] Yes Explain:_____

What are the chief concerns you have related to the position of your teeth or bite:
[ ] Aesthetic [ ] Cleaning [ ] Comfort [ ] Ability to chew [ ] Stability
Please elaborate:_____

What concern has your dentist(s) expressed concerning your bite or dental alignment:
[ ] Wear or fractures of teeth
[ ] Difficulty with cleaning related to alignment of teeth
[ ] Bone or gum tissue loss
[ ] Jaw joint or muscle tightness or discomfort
[ ] Alignment of teeth prior to restorative dental work (crowns, bridges, etc.)
[ ] Other_____

Please check if there is a history of:
[ ] Clenching teeth [ ] Muscular soreness around head & neck [ ] Jaw joint soreness [ ] Jaw joint popping
[ ] Grinding teeth [ ] Headaches (more than normal) [ ] Jaw joint clicking [ ] Ringing in the ears
[ ] Speech problems (If so, which sounds_____)
[ ] Mouth breathing: Awake_____ Asleep_____

Is there any other information that may be helpful?_____

I the undersigned have given the above dental and medical information, have reviewed it and find it accurate. If there are any changes to this record, I will inform this practice.

_____ _____ _____
Patient's signature **Date** **Reviewed by**

FOR DOCTOR'S USE ONLY. PREMEDICATE FOR BANDING / DEBANDING [ ] YES [ ] NO