ORTHODONTIC SPECIALISTS

(513) 772-6500

New Patient Information

Please Complete Both Sides

Patient Information

Date ______________________

Patient Name ______________________ Nickname ______________ SS# ______________

Address ______________________ City ______________ State ______________ Zip ______________

Email ______________________ Birth Date ___/___/_____ Age ______________ Gender __________

Cell Phone ______________________ Home Phone ______________________

School ______________________ Grade ______________

Whom may we thank for referring you to our office? ______________________

Other family members seen by us ______________________

General Dentist ______________________ Address ______________________

Siblings: Name ______________________ Age ____ Name ______________________ Age ____

Who is with the child today?

Name ______________________ Relationship ______________________

Do you have legal custody of this child? (circle one) Yes No

Responsible Party Information — Applies to Minors Only

Father's Name (or Self) ______________________

Address ______________________ City ______________ State ______________ Zip ______________

Email Address ______________________

Cell Phone ______________________ Home Phone ______________ Work Phone ______________

SS# ___-____-____ Birth Date ___/___/_____ DL#______________ Relationship to Patient ______________

Employer ______________________

Mother's Name (or Spouse) ______________________

Address ______________________ City ______________ State ______________ Zip ______________

Email Address ______________________

Cell Phone ______________________ Home Phone ______________ Work Phone ______________

SS# ___-____-____ Birth Date ___/___/_____ DL#______________ Relationship to Patient ______________

Employer ______________________ Person financially responsible for this account Father/Self ❑ Mother ❑

Marital Status: Single ❑ Married ❑ Divorced ❑ Widowed ❑

Orthodontic Insurance Information

Primary Insured Name ______________________ Birth Date ___/___/____ SSN ___-___-___

Insurance Company ______________________ ______________ Group No. ______ Employer ______________

Insurance Co. Address ______________City ______________State ______________Zip ________Phone ______________

Do you have Dual coverage? ❑Yes ❑ No

Secondary Insured Name______________________ Birth Date ___/___/____ SSN ___-___-___

Insurance Company ______________________ Group No. ______________ Employer ______________________

Insurance Co. Address ______________City ______________State ______________Zip ________Phone ______________

Emergency Information

Name of nearest relative not living with you ______________________ Phone ______________________

Complete Address ______________________

DENTAL HISTORY

Why is the patient being seen by the Orthodontist today? ______________

Has the patient ever had any pain or tenderness in the jaw joint (TMJ/TMD) Y N

Has the patient ever had a serious/difficult problem associated with dental work? Y N

Is the patient's water fluoridated? Y N

Is the patient taking fluoridated supplements? Y N

Does the patient brush teeth daily? Y N

Types of bristles? Hard Medium Soft

Floss their teeth daily? Y N

Does the patient like their smile? Y N

Does the patient's gums ever bleed? Y N

MEDICAL HISTORY

Does the patient have a personal physician? Y N

Name: ____

Phone: ________________ Last visit: ____________

Is the patient currently under the care of a doctor?

Y N Explain: __________________________________

Please describe the patient's health:

Good Fair Poor

Please list all drugs the patient is currently taking: ______________________

____

Has the patient ever had any of the following diseases or medical problems?

Y	N	Prosthesis	Y	N	History of Scarlet Fever
Y	N	Heart attack	Y	N	Congenital Heart Def.
Y	N	Cancer	Y	N	Convulsions/Epilepsy
Y	N	Diabetes	Y	N	Abnormal Bleeding
Y	N	Rheum. Fev.	Y	N	Artificial Valves
Y	N	HIV/AIDS	Y	N	Heart Surgery/Pacemkr.
Y	N	Hemophilia	Y	N	Any Stays in Hospital
Y	N	Asthma	Y	N	Kidney/Liver Problems
Y	N	Hepatitis	Y	N	Mitral Valve Prolapse
Y	N	Tuberculosis	Y	N	Artificial Bones/Joints
Y	N	Shingles	Y	N	Sev./Freq. Headaches
Y	N	Fever Blister	Y	N	Hi/Lo Blood Pressure
Y	N	Venereal Disease	Y	N	Drug/Alcohol Abuse
Y	N	Ulcers/Colitis	Y	N	Blood Transfusion
Y	N	Heart Murm.	Y	N	Anemia/Radiation Tmt.
Y	N	Emphysema	Y	N	Glaucoma
Y	N	Sinus Problems	Y	N	Difficulty Breathing
Y	N	Hearing Impairment	Y	N	Handicaps/Disabilities
Y	N	Other:			

Is the patient allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin
Y	N	Codeine	Y	N	Dental Anesthetics
Y	N	Latex	Y	N	Tetracycline
Y	N	Penicillin	Y	N	Other:

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

Does the patient have any of the following habits?

Y	N	Thumb Sucking/Finger Sucking
Y	N	Lip Sucking/Biting
Y	N	Nail Biting
Y	N	Nursing Bottle Habits

FOR WOMEN ONLY:

Are you taking birth control pills? Y N

Are you pregnant? Y N Week #: ______________

Are you nursing? Y N

To the best of my knowledge, all of the preceding answers are true and accurate. If I (or the patient) ever have any change in health status or medications being taken or if I (or the patient) have any abnormal medical test results, I will inform the dentist at the next appointment without fail. I authorize the dental staff to perform the necessary dental services the patient may need during treatment. I also authorize release of any information pertaining to treatment for the purpose of comprehensive filing of insurance claims. I authorize payment of primary insurance benefits directly to the dentist otherwise payable to me. I acknowledge full responsibility for the payment of services at the time of service unless other arrangements are made with this office.

____

Signature Date

OFFICE USE ONLY ---OFFICE USE ONLY --- OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient/guardian.

Initials: __________________________ Date: ________________

Doctor's comments: ____________________________________

____

Medical History Update:

1. Date: ____________ Signature: ________________

Comments: ____________________________________

2. Date: ____________ Signature: ________________

Comments: ____________________________________