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solutions
Orthodontic Care for Children and Adults
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NJ SPEC #5238

Patient Information

Welcome

To assist us in providing the most comprehensive care, please provide the following personal information and health history.

Today's Date:_______________

Name:____ Nickname:____________________

Gender _______ Age______ Birth date:_____/_____/_____

Home Address:_______________________________________City:_______________________

State:_________ Zip code:___________ Cell Phone: (____)______________________

EMAIL:________________________________

Patient's Dentist: _________________________________ **Date of Last Visit:**_________________

Whom may we thank for referring you?____

Orthodontic Concerns:

Parent /Guardian Information

*** If parents are separated/ divorced, please indicate the person who is financially responsible_______________***

Parent Information	**Parent Information**
Name _________________________	Name ____________________________
Address ________________________	Address ___________________________
_____________________________	_________________________________
Mobile (_____)__________________	Mobile(_____)____________________
Email__________________________	Email ______________________________
Employed by ___________________	Employed by _______________________
Birth date: _____________________	Birth date: __________________________
SSN:____________________________	SSN:_______________________________
Relationship to Patient _________________	Relationship to Patient__________________

Emergency Information

Name of nearest relative not living with you:____

Complete address:____

Home Phone:(______)_________Cell phone:(______)_________ Work Phone: (______)_________

Please complete next page

Medical History

1. Are you under the care of a physician? •Yes •No
   If yes, what condition? ______________________________

2. Are you currently taking any medication? •Yes •No
   If yes, please list medications:______________________________

3. Do you have or have you had any of the following problems or diseases? (check if yes)
   •Heart Murmur – If yes, do you take medication prior to dental appointments? •Yes •No
   •Heart Problems
   •Hepatitis, Jaundice or Liver Disease
   •Asthma or Hay Fever
   •Diabetes
   •Aids
   •Other______________________________

4. Are you allergic to any of the following?
   Drugs/medications (such as penicillin, codeine, aspirin) Yes No
   Latex allergy? Yes No
   Any Metals/ Plastics •Yes •No
   If yes, what are you allergic to?______________________________

5. Do you have any disease, condition or other problems not listed that you think we should know about? •Yes •No
   If yes, describe:______________________________

Dental History

1. Do you have any pending dental work? •Yes •No
   If yes, what?______________________________

2. When was your last dental check-up?______________________________

3. When was your last dental cleaning?______________________________

4. Have you ever had any abnormal bleeding associated with previous extractions, surgery or trauma? •Yes •No

5. Do your gums bleed? •Yes •No

6. Are you aware of grinding or clenching your teeth? •Yes •No

7. Have there been any injuries to face, mouth or teeth? •Yes •No

8. Do you have any speech problems? •Yes •No

9. Have you ever been told of any missing or extra permanent teeth? •Yes •No

10. Do you experience pain or clicking in your jaw, ear or facial muscles upon opening your mouth? •Yes •No
    Headaches? •Yes •No
    Please describe:______________________________

12. Why are you seeking an orthodontic consultation?______________________________

____

Please complete next page

Dental Insurance Information

If you have more than one dental Insurance plan the primary plan belongs to the parent whose birthday is earliest in the year. Please fill out all information. If any information is missing or not available we will not be able to complete your claim form. Please understand that your plan(s) may not include orthodontic coverage and that those plans that do have orthodontic benefits never cover the entire fee.

Primary Plan

Insured's Name :_________________________________ Relation to Patient:_________________

SSN / I. D. #: ______________________ Birth Date: ______/______/______

Insurance Name:___________________________________

Group #:_____________

Phone: (_______) _________- __________

Employer :____

Secondary Plan

Do you have secondary insurance coverage? • Yes • No If yes:

Insured's Name:_________________________________Relation to Patient:___________________

SSN/ I. D. #: ______________________ Birth Date: ______/______/______

Insurance Name:______________________

Group #:_____________

Phone: (_______)________- ___________

Employer:____

Additional Plan

Insured's Name:______________________________Relation to Patient:___________________

Social Security/I. D. #: ______________________ Birth Date: ______/______/______

Insurance Name:______________________ Group #:_____________

Phone: (_______)________- ___________

Employer:____