WELCOME

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The benefits of a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset.
Please fill out this form completely. The better we communicate, the better we can care for you.

1 About You

Today's Date: _____

Email Address: _____

Name:_____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: ____/____/____ Age: _____ SS #:_____

Home Address: _____
APT/CONDO #:

_____
CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (_____) _____ Cell / Other #: _____

Wk #: (_____) _____ Ext: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

General Dentist: _____

Last Visit Date: _____

2 Spouse Information

His / Her Name: _____

Employer: _____

Wk #: (_____) _____Ext: _____ SS #:_____

Birthdate: _____/_____/_____

3 Orthodontic Insurance

Primary

Orthodontic Coverage: ☐ Yes ☐ No Dental Coverage:☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (_____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's SS#:_____

Insured's Employer: _____

Secondary

Orthodontic Coverage: ☐ Yes ☐ No Dental Coverage:☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (_____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation:_____

Insured's Birthdate: ___/___/___ Insured's SS#:_____

Insured's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: _____ Relation: _____

Wk #: (_____) _____ Hm#: (_____) _____

Person Responsible for Account: _____

Wk #: (_____)_____Ext:_____ Hm#:(_____) _____

Billing Address: _____

Relation: _____ SS #: _____

Employer: _____

4 MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Phone #: (_____) _____ Date of last visit: _____

CONTINUED ON BACK

4 MEDICAL HISTORY *continued*

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

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Are you taking any prescription/over-the-counter medications? ☐ Yes ☐ No

Please list each one: _____

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #:_____

Are you nursing? ☐ Yes ☐ No

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

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

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

Are you allergic to any of the following?

Y N	Aspirin	Y N	Dental Anesthetics	Y N	Penicillin
Y N	Any Metals/Plastics	Y N	Erythromycin	Y N	Tetracycline
Y N	Codeine	Y N	Latex	Y N	Other

Please list any other drugs/materials that you are allergic to: _____

_____

5 DENTAL HISTORY

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

_____

Have you ever had or been evaluated for orthodontic treatment? ☐ Yes ☐ No

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain/ Discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

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

Do you like your smile? ☐ Yes ☐ No Gums ever bleed? ☐ Yes ☐ No

Have you ever had an injury to your: Mouth Teeth Chin (please circle)

Do you have any speech problems?_____

Do you generally breathe through your mouth? ☐ Yes ☐ No
If yes, please circle: While Awake? While Asleep?

Do you have any missing or extra permanent teeth? ☐ Yes ☐ No

Have you ever taken Phen-Fen? (Also known as Redux or Pondimin) ☐ Yes ☐ No

Do you smoke or use tobacco in any form? ☐ Yes ☐ No

- I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.
- Our Privacy Policy is on our website: www.merrillorthodontics.com. If you would like a paper copy, please request one.
- The Patient is responsible for payment. **I hereby authorize OrthoBanc, LLC, on behalf of Merrill Orthodontics to obtain a copy of my credit report from a credit reporting agency for the purpose of considering payment options.**
  NOTE: *Obtaining an OrthoBanc credit recommendation does not alter the responsible party's credit score in any way*

_____
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.

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY**

I verbally reviewed the medical / dental information above with the patient named herein. Initials:_____ Date:_____

Doctor's Comments:

_____

_____

_____