1. Patient information:

Patient First Name: _____ Middle Initials: _____ Patient Last Name: _____

Date of Birth: _____ Gender: ○ Female ○ Male ○ Other Preferred Pronouns: _____

Marital Status: ○ Single ○ Married Street Address: _____ Apt./Unit #: _____ City: _____

State: _____ Zip Code: _____ Mobile Phone: _____ Home Phone: _____

Work Phone: _____ Email: _____

Employer: _____

Preferred contact method: ○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email

2. Responsible Party Information (if different from previous listing):

First Name: _____ Middle Initials: _____ Last Name: _____

Date of Birth: _____ Gender: ○ Female ○ Male ○ Other Marital Status: ○ Single ○ Married

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Employer: _____

Preferred contact method: ○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email

3. How did you learn about our practice / whom may we thank for referring you?

Referral Source

☐ Google ☐ Social Media ☐ Sign or Billboard ☐ Insurance Provider List

Friend or family (enter name) _____ Dentist (enter name): _____

Other Website _____ Other _____

4. What is your primary concern?

_____

5. Have you previously had orthodontic treatment?

○ Yes ○ No

6. Have you had a consultation with an orthodontist previously?

○ Yes ○ No

If yes, name of orthodontist:

_____

7. Who is your primary care physician?

_____

8. General Dentist Information:

Dentist Name: _____

Dental visit in last 6 months?: ○ Yes ○ No

Any scheduled treatments? _____

9. Do you have Orthodontic Insurance?

○ Yes ○ No

10. Primary Insurance

Primary Insurance Company _____

Member ID / Policy # _____

Group Number _____

Patient Relationship to Insured ○ Self ○ Spouse ○ Child ○ Other

Insured Name _____

Insured Phone # _____

Insured Date of Birth _____

Insured Street Address _____

Insured City _____

Insured State _____

Zip Code _____

11. Primary Insurance Card: Please take a photo of the FRONT of your insurance card. Should treatment be recommended, providing your insurance card will allow us to share the portion of your orthodontic treatment fee covered by your plan.

12. Primary Insurance Card: Please take a photo of the BACK of your insurance card. Should treatment be recommended, providing your insurance card will allow us to share the portion of your orthodontic treatment fee covered by your plan.

13. Do you have Secondary Orthodontic Insurance?

○ Yes ○ No

14. Secondary Dental Insurance

Secondary Insurance Company _____

Member ID / Policy # _____

Group Number _____

Patient Relationship to Insured ○ Self ○ Spouse ○ Child ○ Other

Insured Name _____

Insured Phone # _____

Insured Date of Birth _____

Insured Street Address _____

Insured City _____

Insured State _____

Zip Code _____

15. Secondary Insurance Card: Please take a photo of the FRONT of your insurance card. Should treatment be recommended, providing your insurance card will allow us to share the portion of your orthodontic treatment fee covered by your plan.

16. Secondary Insurance Card: Please take a photo of the BACK of your insurance card. Should treatment be recommended, providing your insurance card will allow us to share the portion of your orthodontic treatment fee covered by your plan.

17. Do you have, or have you had, any of the following (check all that apply)? If checked "Yes" please explain.

- ☐ Anemia
- ☐ Blood disorder
- ☐ Bleeding abnormality
- ☐ Tumor or growth
- ☐ Cancer treatment
- ☐ Radiation treatment
- ☐ Diabetes/ Hypoglycemia
- ☐ Endocrine/ Thyroid problems
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Stroke
- ☐ Rheumatic fever
- ☐ Pacemaker
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Bone disorder
- ☐ Joint replacement
- ☐ Rheumatoid arthritis
- ☐ Asthma/COPD
- ☐ Epilepsy
- ☐ Convulsions/ Seizures
- ☐ Fainting/ Dizziness
- ☐ Headaches/ Migraines
- ☐ GERD/ Acid reflux
- ☐ HIV/ AIDS
- ☐ Herpes
- ☐ Hepatitis B or C
- ☐ Attention deficit disorder
- ☐ Nervous disorder
- ☐ Anxiety
- ☐ Depression
- ☐ Psychiatric treatment
- ☐ Tobacco/ Vape/ Nicotine use
- ☐ Recreational drug use
- ☐ Current pregnancy

Please add details, and approximate age when condition occurred if not current, for any yes answers above:

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18. Indicate any history of (check all that apply); if checked "Yes", please explain.

- ☐ Thumb/Finger sucking
- ☐ Nail biting
- ☐ Tongue and/or swallowing problems
- ☐ Speech problems
- ☐ Mouth breathing
- ☐ Tonsils and adenoids removed
- ☐ Snoring
- ☐ Sleep apnea
- ☐ Grinding and/or clenching of teeth
- ☐ Jaw pain
- ☐ Clicking or popping jaw
- ☐ Difficulty opening or closing jaw
- ☐ History of wearing a mouthguard at night
- ☐ Loose teeth or broken fillings
- ☐ Crowns/Bridges
- ☐ Root canals
- ☐ Bleeding gums
- ☐ History of periodontal disease
- ☐ History of periodontal treatment
- ☐ Mouth sores
- ☐ Cold sores
- ☐ Injury to face or teeth
- ☐ Sensitivity when biting
- ☐ Cold, hot, or sweets sensitivity
- ☐ Food collection between certain teeth
- ☐ Missing teeth
- ☐ Extra teeth

Other/Details:

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19. Please list any food, drug, or contact allergies:

	Allergy
1	

20. List medications you are currently taking and the correlating diagnosis:

	Medication	Diagnosis
1		

21. Any serious illnesses, hospitalizations, or other health conditions not listed elsewhere on this form? If yes, please describe.

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22. What treatment option(s) interest you? Check all that apply.

- ☐ Invisalign/ Clear aligners
- ☐ Metal Braces
- ☐ Clear braces
- ☐ Retainers only

Other:

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23. If treatment is recommended, how soon would you like to proceed?

☐ ASAP ☐ Within the month ☐ Undecided

Other:

_____

24. What payment option(s) would you like to review?

☐ No-Interest Monthly Payments ☐ Payment in Full w/Special Courtesy ☐ HSA/FSA

Other:

_____

25. Is there anything else you would like us to know before your visit?:

_____

To the best of my knowledge, the above questions have been accurately answered. I am aware it is my responsibility to inform this office of any changes to my medical status. I permit to perform necessary orthodontic records, and I am aware you may use these records for in-office education.

_____ _____

Signature Date