180 ORTHODONTICS

19053 Bagley Rd. Suite 1
Middleburg Heights, Ohio 44130
(440) 243-9575

PATIENT INFORMATION (please know that we respect and protect your privacy)

Preferred Name _____ Birthdate _____Sex _____

Home Address: Street _____

City _____ State_____ Zip _____Home Phone _____

Mobile Phone _____ Work Phone _____D.L.#_____

Email address _____ Marital Status _____

Employer Name & Address_____

How long there? _____ Occupation_____

Who may we thank for referring you? _____

Other family members seen by us _____

General Dentist _____ Phone _____

RESPONSIBLE PARTY INFORMATION

Last _____First _____MI _____

Billing Address: _____

Relation _____SS#_____

Employer _____DL# _____

EMERGENCY CONTACT INFORMATION

Name _____Relation _____
Work #_____Mobile # _____Home # _____

PRIMARY & SECONDARY DENTAL INSURANCE – ORTHODONTIC BENEFITS: YES/NO

Insured's Full Name _____ Birthdate _____

SS# _____ Relationship to Patient _____

Insurance Co_____ Employer _____

Insurance Address _____ Ins Phone _____

Contract ID _____ Group #_____

Insured's Full Name _____ Birthdate _____

SS# _____ Relationship to Patient _____

Insurance Co_____ Employer _____

Insurance Address _____ Ins Phone _____

Contract ID _____ Group #_____

DENTAL HISTORY

Main concerns that you would like orthodontics to accomplish? _____

Have you ever been evaluated for orthodontic treatment? _____

Have you ever had a serious problem associated with any previous dental work? _____

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? _____

Have you ever had an injury to face, mouth or teeth? _____

Do you have any missing or extra permanent teeth? _____

Have you ever taken Phen-Fen, Fosamax or any other bisphosphonate? _____

Please check any of the following conditions that apply:

☐ Bleeding	☐ False teeth	☐ Mouth breather	☐ Sensitivity to hot
☐ Bridgework	☐ Grinding teeth	☐ Partial dentures	☐ Sensitivity to biting
☐ Crowns	☐ Loose teeth	☐ Sensitivity to cold	☐ Smoke or use tobacco

MEDICAL HISTORY

Name of Physician _____ Date of Last visit _____

Please list all medications you are currently taking? _____

Allergies (drugs/latex/nickel/any other _____

(Women) Is patient pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control? ☐ Yes ☐ No

Have you ever had any of the following medical problems?

☐Abnormal bleeding	☐ Drug/alcohol abuse	☐ Hepatitis	☐ Radiation treatment
☐ Anemia	☐ Emphysema	☐ Blood Pressure H/L	☐ Rheumatic/Scarlet fever
☐ Artificial bones/joints/valves	☐ Epilepsy/Seizures/Fainting	☐ Heart attack/stroke	☐ Severe/frequent headaches
☐ Asthma/arthritis	☐ Fever Blisters/Herpes	☐ HIV^+ /AIDS	☐ Shingles
☐ Blood transfusion	☐ Glaucoma	☐ Kidney problems	☐ Sickle cell disease/Traits
☐ Cancer/Chemotherapy	☐ Heart attack/Stroke	☐ Liver problems	☐ Sinus problems
☐ Chemotherapy	☐ Heart murmur	☐ Major surgery	☐ Tuberculosis (TB)
☐ Diabetes	☐ Heart surgery/Pacemaker	☐ Mitral valve Prolapse	☐ Ulcers/Colitis
☐ Difficulty breathing	☐ Hemophilia	☐ Psychiatric care	☐ Venereal disease

Please list any serious medical conditions that you have ever had _____
Please list any drugs/materials that you are allergic to _____

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office.

_____ _____
Signature Date

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____ _____
Signature Date