Premier Smiles Orthodontics

WELCOME

ADULT PATIENT INFORMATION

Date: _____

Patient's Name: _____
last first middle

Residence: _____
Street City Zip

Mailing Address: _____
Street City Zip

How long at this address? _____

Previous Address (If less than 3 years)

_____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Birthdate: _____ Social Security # _____

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

Employer: _____

Occupation: _____

No. of years employed: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Spouse's Name: _____

Relationship to Patient? _____

Employer: _____

Occupation: _____ No. of years employed: _____

Social Security #: _____ Birthdate: _____

Work Phone: _____ Cell Phone: _____

DENTAL INSURANCE INFORMATION

Insured's Name: _____

Insurance Company: _____

Insurance Co. Address: _____

Insured's Social Security #:
_____

Group No.: _____ Local No.:
_____

Phone Number: _____

Do you have dual coverage? Yes: ____ No: ____

If yes:

Insured's Name: _____

Insurance Company: _____

Insurance Co. Address: _____

Insured's Social Security #: _____

Group No.: _____ Local No.:
_____

Phone Number: _____

EMERGENCY INFORMATION

Name of nearest relative not living with you: _____

Complete Address: _____
Street City Zip

Work Phone #: _____ Home Phone #: _____ Cell Phone #: _____

I understand that, where appropriate, credit bureau reports may be obtained.

Signature: _____

Updates (date & initial): _____

Dental History

General Dentist: _____
Date of last visit: _____
What concerns you most about your teeth?
_____
_____

Is the patient currently experiencing any dental pain?	□ Yes □ No
Ever experienced any unfavorable reaction to dentistry?	□ Yes □ No
Has the patient ever lost or chipped a tooth?	□ Yes □ No
Have there ever been any injuries to the face, mouth, or teeth?	□ Yes □ No
Is there any part of your mouth that is sensitive to temperature?	□ Yes □ No
Is there any part of your mouth that is sensitive to pressure?	□ Yes □ No
Do your gums bleed when brushing your teeth?	□ Yes □ No
Any type of thumb or tongue habits?	□ Yes □ No
Is the patient a mouth breather?	□ Yes □ No
Has the patient ever seen an orthodontist? If yes, who and when? _____	□ Yes □ No
What is the patient's attitude toward receiving orthodontic treatment? _____ _____	
Has anyone in the family received orthodontic treatment? How did they feel about the results? _____ _____	□ Yes □ No
Do teeth or jaw ever feel uncomfortable in the morning?	□ Yes □ No
Ever experienced jaw clicking or popping?	□ Yes □ No
Aware of any clenching or grinding of teeth during the day?	□ Yes □ No
Ever experienced "tension" headaches?	□ Yes □ No
Has the patient ever experienced chronic ringing in the ears?	□ Yes □ No
Does the patient need extra help with instructions?	□ Yes □ No
Is the patient sensitive or self-conscious about his/her teeth?	□ Yes □ No
Are you aware that some appointments will be during work hours?	□ Yes □ No

Medical History

Physician: _____
Date of last visit: _____
Address: _____
Phone Number: _____

Please check Yes or No to the following (If yes, please fill in details)

Is the patient currently taking any medications? _____	□ Yes □ No
Is the patient allergic to any medications? _____	□ Yes □ No
History of major illnesses? _____ _____	□ Yes □ No
Has the patient ever had any operations? _____	□ Yes □ No
Has seen a physician in the last 12 months? _____	□ Yes □ No
FEMALE PATIENTS ONLY Is the patient pregnant?	□ Yes □ No

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout or lifetime and there can be some movement and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. _____ to perform a complete orthodontic evaluation.

_____ Signature

_____ Date