COASTAL ORTHODONTIC CARE

WELCOME

About You

Today's Date:_____

E-mail 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 ☐Partnered ☐Divorced/Separated ☐Widowed

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

Wk #: (_____)_____ Ext:_____ DL #:_____

Employer:_____

Employer's Address:_____

_____
City State Zip

How Long there?_____ Occupation:_____

Where & when are the best times to reach you?_____

Whom may we Thank for referring you?_____

Other family members seen by us:_____

Previous / Present Dentist:_____
(Please Circle)

Person Responsible for Account:_____

Spouse Information

His / Her Name:_____

Employer:_____

Wk #: (_____)_____ Ext:_____ SS#:_____

Birthdate:____/____/____ DL #:_____

Relative or Friend not living with you (for emergency).

His / Her Name:_____ Relation:_____

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

Orthodontic Insurance

Primary

Orthodontic Coverage? ☐Yes ☐No Dental Coverage? ☐Yes ☐No

Insurance Co. Name:_____

Insurance Co. Address:_____

_____
City State Zip

Insurance Co. Phone #: (_____)_____

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

Insured's Name:_____ Relation:_____

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

Insured's Employer:_____

Employer's Address:_____

_____
City State Zip

Secondary

Orthodontic Coverage? ☐Yes ☐No Dental Coverage? ☐Yes ☐No

Insurance Co. Name:_____

Insurance Co. Address:_____

_____
City State Zip

Insurance Co. Phone #: (_____)_____

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

Insured's Name:_____ Relation:_____

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

Insured's Employer:_____

Employer's Address:_____

_____
City State Zip

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts insurance, 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. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____
Signature Date

Continued on Back

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name:_____

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

Your Current Physical health is: ☐Good ☐Fair ☐Poor

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

Please explain:_____

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

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

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

Please list each one:_____

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

If so, when?_____

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

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 / Hemophilia	Y	N	Herpes / Fever Blisters
Y	N	AIDS	Y	N	High Blood Pressure
Y	N	Alcohol / Drug Abuse	Y	N	HIV
Y	N	Anemia	Y	N	Hospitalized for Any Reason
Y	N	Arthritis	Y	N	Kidney Problems
Y	N	Artificial Bones/Joints/Valves	Y	N	Liver Disease
Y	N	Asthma	Y	N	Low Blood Pressure
Y	N	Blood Transfusion	Y	N	Lupus
Y	N	Cancer / Chemotherapy	Y	N	Mitral Valve Prolapse
Y	N	Colitis	Y	N	Pacemaker
Y	N	Congenital Heart Defect	Y	N	Psychiatric Problems
Y	N	Diabetes	Y	N	Radiation Treatment
Y	N	Difficulty Breathing	Y	N	Rheumatic / Scarlet Fever
Y	N	Emphysema	Y	N	Seizures
Y	N	Epilepsy	Y	N	Shingles
Y	N	Fainting Spells	Y	N	Sickle Cell Disease / Traits
Y	N	Frequent Headaches	Y	N	Sinus Problems
Y	N	Glaucoma	Y	N	Stroke
Y	N	Hay Fever	Y	N	Thyroid Problems
Y	N	Heart Attack / Surgery	Y	N	Tuberculosis (TB)
Y	N	Heart Murmur	Y	N	Ulcers
Y	N	Hepatitis	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	Erythromycin	Y	N	Penicillin
Y	N	Codeine	Y	N	Jewelry/Metals	Y	N	Tetracycline
Y	N	Dental Anesthetics	Y	N	Latex	Y	N	Other

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

_____

Dental History

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

_____

_____

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 still have wisdom teeth? ☐ 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

Are you happy with the way your smile looks? ☐ Yes ☐ No

If not, what would you change?_____

_____

_____

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 that it is my responsibilty 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. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

Signature Date

OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information with the patient named herein.

Initials:_____ Date:_____

Doctor's Comments:_____

_____

_____

_____

_____

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.

Medical History Update

Has there been any change in your health status since your last visit? Y ☐ N ☐

If Yes, please explain._____

_____

Has there been any change in your health status since your last visit? Y ☐ N ☐

If Yes, please explain._____

_____

_____ _____

Patient Signature Date

_____ _____

Dentist Signature Date

_____ _____

Patient Signature Date

_____ _____

Dentist Signature Date