

*Welcome to our practice! We thank you for choosing our office for your orthodontic needs. Our goal is to make your orthodontic experience as productive and pleasant as possible. We promote preventive care and encourage proper oral hygiene to achieve and maintain optimal aesthetics, function, stability and oral health. We take great pride in creating beautiful smiles to last a lifetime.*

Today's Date \_\_\_\_\_

Patient ID \_\_\_\_\_ Model # \_\_\_\_\_

**PATIENT INFORMATION**

Patient's Name \_\_\_\_\_ Nickname \_\_\_\_\_ Sex: M F Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Social Security # \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_  
School or Employer \_\_\_\_\_ Grade or Occupation \_\_\_\_\_  
Do You Anticipate a Move or Transfer in the Near Future? \_\_\_\_\_ If So, When? \_\_\_\_\_  
How Did You Hear About Us? \_\_\_\_\_ Other Family Members or Friends Seen By Us \_\_\_\_\_  
Siblings or Children: YES NO Name/Age \_\_\_\_\_ Name/Age \_\_\_\_\_ Name/Age \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

Responsible Party \_\_\_\_\_ Relationship To Patient \_\_\_\_\_ Marital Status: S M W D  
Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Own or Rent? \_\_\_\_\_ How Long At This Address? \_\_\_\_\_ Mailing Address (if different from above) \_\_\_\_\_  
Social Security # \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_  
Drivers License # \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_ # of Years Employed \_\_\_\_\_  
Employer Address \_\_\_\_\_ Work Phone \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_  
Drivers License # \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_ # of Years Employed \_\_\_\_\_  
Employer Address \_\_\_\_\_ Work Phone \_\_\_\_\_  
(If Separate Ledger Requested, Please Indicate Additional Responsible Party)  
2<sup>nd</sup> Responsible Party \_\_\_\_\_ Relationship To Patient \_\_\_\_\_ Marital Status: S M W D  
Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Own or Rent? \_\_\_\_\_ How Long At This Address? \_\_\_\_\_ Mailing Address (if different from above) \_\_\_\_\_  
Social Security # \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_  
Drivers License # \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_ # of Years Employed \_\_\_\_\_  
Employer Address \_\_\_\_\_ Work Phone \_\_\_\_\_

**ORTHODONTIC INSURANCE INFORMATION**

Primary Insured's Name \_\_\_\_\_ Insured's Birthdate \_\_\_\_\_ Insured's SSN \_\_\_\_\_  
Insured's Employer \_\_\_\_\_ Employer Address \_\_\_\_\_ Employer Phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Insurance Phone \_\_\_\_\_  
Insurance Address \_\_\_\_\_ Insurance Fax or Website \_\_\_\_\_  
Do You Have Dual Coverage? YES NO  
Secondary Insured's Name \_\_\_\_\_ Insured's Birthdate \_\_\_\_\_ Insured's SSN \_\_\_\_\_  
Insured's Employer \_\_\_\_\_ Employer Address \_\_\_\_\_ Employer Phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Insurance Phone \_\_\_\_\_  
Insurance Address \_\_\_\_\_ Insurance Fax or Website \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Name of Nearest Relative Not Living with Patient \_\_\_\_\_ Relation \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**MEDICAL HISTORY**

Physician \_\_\_\_\_ Date of Last Visit \_\_\_\_\_ Current Medical Status: Good Fair Poor

Address \_\_\_\_\_ Phone \_\_\_\_\_

Please circle YES or NO. (If YES, please specify.)

YES NO Are you taking any prescription or over-the-counter medication(s)? \_\_\_\_\_

YES NO Do you have any allergies (food, metal, plastic, latex or drug)? \_\_\_\_\_

YES NO Do you have a history of major illness, hospitalization or serious accident? \_\_\_\_\_

Please circle any of the medical conditions that you have had or currently have.

- |                 |                            |                            |                                        |                      |
|-----------------|----------------------------|----------------------------|----------------------------------------|----------------------|
| AIDS            | Diabetes                   | Handicaps / Disabilities   | Kidney Disorders                       | Rheumatic Fever      |
| Arthritis       | Dizziness / Fainting       | Heart Problems             | Liver Disorders                        | Sensory Difficulties |
| Asthma          | Drug / Alcohol Abuse       | Hepatitis                  | Musculoskeletal Disorders              | Speech Problems      |
| Birth Defects   | Endocrine Disorders        | Herpes                     | Pneumonia                              | Tobacco Habit        |
| Blood Disorders | Epilepsy                   | High or Low Blood Pressure | Psychological / Psychiatric Conditions | Tuberculosis         |
| Bone Disorders  | Gastrointestinal Disorders | Immunological Disorders    | Respiratory Disorders / Difficulties   | Tumor or Cancer      |

Are there any other medical / clinical / family conditions or history that we should be aware of? \_\_\_\_\_

If child, have you reached puberty (girls: menstruation started; boys: voice changed)? YES NO If so, approximately when? \_\_\_\_\_

If woman, are you pregnant? YES, Week # \_\_\_\_\_ NO Nursing? YES NO

**DENTAL HISTORY**

Dentist \_\_\_\_\_ Date of Last Cleaning \_\_\_\_\_ Current Dental Status: Good Fair Poor

Address \_\_\_\_\_ Phone \_\_\_\_\_

**WHAT CONCERNS YOU MOST ABOUT YOUR TEETH, BITE OR SMILE? WHY ARE YOU HERE TODAY?** \_\_\_\_\_

YES NO Are you presently in any dental pain or discomfort? Any sensitivity to pressure hot, cold or sweet? \_\_\_\_\_

YES NO Have you had any serious or difficult problems with previous dental work? \_\_\_\_\_

YES NO Any history of trauma to the face, teeth, jaw or chin? \_\_\_\_\_ Chipped or injured teeth? \_\_\_\_\_

YES NO Do your gums bleed? Have you been told you have, or been treated for gum problems, attachment / bone loss or periodontal disease? \_\_\_\_\_

YES NO Have you ever experienced pain, discomfort or noise in your jaw joint? \_\_\_\_\_

YES NO Have you been informed of any congenitally missing or supernumerary (extra) teeth? \_\_\_\_\_

YES NO Any family members with history of jaw surgery? \_\_\_\_\_

Do you have (had) any of the following habits? (Please check all that apply.)

- |                                                  |                                               |                                      |                                                  |
|--------------------------------------------------|-----------------------------------------------|--------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Chewing Snuff / Tobacco | <input type="checkbox"/> Lip Sucking / Biting | <input type="checkbox"/> Nail Biting | <input type="checkbox"/> Thumb or Finger Sucking |
| <input type="checkbox"/> Clenching / Grinding    | <input type="checkbox"/> Mouth Breathing      | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Tongue Thrust or Lisp   |

YES NO Have you ever been evaluated for braces (or had braces) before? \_\_\_\_\_

What do you consider to be the main benefit(s) of orthodontic correction?

- |                                   |                                     |                                                    |                                      |
|-----------------------------------|-------------------------------------|----------------------------------------------------|--------------------------------------|
| <input type="checkbox"/> Cosmetic | <input type="checkbox"/> Functional | <input type="checkbox"/> Psychological / Emotional | <input type="checkbox"/> Other _____ |
|-----------------------------------|-------------------------------------|----------------------------------------------------|--------------------------------------|

Attitude(s) toward orthodontic treatment?

- |                                       |                                      |                                       |                                      |
|---------------------------------------|--------------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Enthusiastic | <input type="checkbox"/> Indifferent | <input type="checkbox"/> Apprehensive | <input type="checkbox"/> Other _____ |
|---------------------------------------|--------------------------------------|---------------------------------------|--------------------------------------|

**SIGNATURE**

I certify that the information I have given is correct to the best of my knowledge and that it will be held in the strictest confidence. I understand that it is my responsibility to inform this office of changes in medical/dental status. I authorize the orthodontic staff to perform any necessary services for diagnosis and treatment with my informed consent. I also relinquish any and all rights to the use of photographs and records made in the process of examination, treatment and retention by Dr. Yurkiewicz (including, but not limited to publication in professional journals, research or education). I understand that late payments over 30 days are subject to a 1.5% finance fee. If applicable, I authorize insurance payment of orthodontic benefits directly to this office as well as authorize release of all information necessary to secure payment. I agree to pay any fees not paid by insurance and all collection fees, should my account become delinquent. Finally, I authorize this office to verify my credit history prior to extending credit to me for any treatment fees, and that this office may use the services of one or more credit reporting agencies.

Signature of Patient / Parent or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

Office Use Only

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_