Lisa A. Yurkiewicz, D.M.D., M.S.

Specialist in Orthodontics and Dentofacial Orthopedics

www.DrLisaY.com

Welcome! Thank you for choosing our office for your orthodontic needs. Our goal is to make your experience as productive and pleasant as possible. We promote preventive care and encourage proper oral hygiene to help you achieve and maintain optimal aesthetics, function, stability and oral health. We are committed to exceeding your expectations. Congratulations, you've taken the first step to achieve a natural, healthy and beautiful smile for a lifetime!

PATIENT INFORMATION **Date**______________**Pt #**_____________**Model #**__________

Patient Name____Nickname___________ Sex: M F Birthdate___________Age_____

Address____City_______________State___________Zip_______________

Social Security #______________________Home Phone________________________Cell Phone_________________________________

School or Employer ___________________________Grade or Occupation________________ Email_____________________

Do You Expect to Move or Transfer in the Near Future? Y N If Yes, 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)_____________________________

Social Security #__________________ Birthdate___________________ Phone_____________Email___________________________

Driver's License #____________________Employer__________________Occupation___________________# of Years Employed_____

Employer Address____Work Phone__________________________

Spouse's Name_______________________________________ Social Security #__________________ Birthdate__________________

Driver's License #____________________Employer__________________Occupation___________________# of Years Employed_____

Employer Address____Work Phone_______________________

(If Separate Accounts Requested, Please Indicate Additional Responsible Party)

2nd 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)____
Social Security #__________________ Birthdate___________________ Phone_____________Email___________________________
Driver's 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 and Phone____
Insurance Company and Phone____Group #___________________________
Insurance Company Address____Fax or Website___________________________

EMERGENCY CONTACT INFORMATION

Name of Nearest Relative or Friend Not Living with Patient______________________________________Home Phone______________

Address____Work Phone_____________________Cell Phone_____________________

MEDICAL HISTORY

Physician____Date of Last Visit___________________Current Medical Status: Good Fair Poor

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

YES NO Are you taking any prescription or over-the-counter medications?____

YES NO Do you have any allergies (e.g. metal, latex, drug, plastic, or food)?____

YES NO Do you have history of major illness, hospitalization or serious accident?____

Please circle any of the following 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 Defect	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	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?_________________

DENTAL HISTORY

Dentist____Date of Last Cleaning__________________Current Dental Status: Good Fair Poor

WHAT CONCERNS YOU MOST ABOUT YOUR TEETH, BITE or SMILE? Why Are You Here Today?_____________________________
____

YES NO Are you presently in dental pain / discomfort or have tooth sensitivity to pressure, hot, cold or sweet?
YES NO Any history of significant trauma to the face, jaw or chin? Chipped or injured teeth? Jaw joint (TMJ) pain or discomfort?
YES NO Do your gums bleed? Have you ever been treated for gum problems, attachment loss, bone loss or periodontal disease?
YES NO Have you been informed of any congenitally missing or supernumerary (extra) teeth?

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

☐ Chewing Snuff / Tobacco	☐ Lip Sucking / Biting	☐ Nail Biting	☐ Thumb or Finger Sucking
☐ Clenching / Grinding	☐ Mouth Breathing	☐ Sleep Apnea	☐ Tongue Thrust or Lisp

YES NO Have You Ever Been Evaluated For Braces (or Had Braces) Before? ____
If parent of child, did you have prior orthodontics? NO YES If yes, have you experienced relapse (teeth shifted)? NO YES

What you consider to be the main benefit(s) of orthodontic correction?
☐ Cosmetic ☐ Functional ☐ Psychological / Emotional ☐ Other __________________________________

Patient's attitude(s) toward orthodontic treatment?
☐ Enthusiastic ☐ Indifferent ☐ Apprehensive ☐ Other___________________________________

SIGNATURE

I certify that the information I have given is complete and correct to the best of my knowledge and that it will be held in the strictest confidence. I understand 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. I give permission for any photographs, X-rays and study models to be used at scientific meetings, presentations and publications of a scientific nature or study group to advance the art, science and education of orthodontics. I understand that late payments over 30 days are subject to a 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. I authorize this office to verify my credit history prior to extending credit to me, and that this office may use the services of one or more credit reporting agencies. In case of divorce, I accept that the accompanying parent will pay for services and seek reimbursement from other parent. Finally, I understand that the Notice of Patient Privacy Act is accessible in the reception area for my review and a copy is provided upon request.

Signature of Patient / Parent or Legal Guardian ____Date________________________