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Smiles Ahead Orthodontics Patient Information

The Following Information and History are Necessary for Adequate Treatment and Understanding of Your Care.

Thank You for Completing in Full

Date_____

Patient's name _____
Last First Middle

Prefers to be called:_____

Address _____
Street City Zip

Home Phone_____ Birth Date_____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

Email Address:_____

Other family members in our practice:_____

School patient attends:_____

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

Responsible Party Information

Name_____
Last First Middle

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

How long at this address?_____ Home phone_____ Work phone _____

Email Address:_____ Cell Phone:_____

Previous Address (If less than 3 years) _____

Social Security #_____ Birth Date_____ Relationship to Patient _____

Employer_____ Occupation_____ No. years employed _____

Spouse's Name_____ Relationship to Patient_____

Employer_____ Occupation_____ No. years employed _____

Social Security # _____ Birth Date _____ Work Phone _____

Whom does patient live:_____

Phone Numbers for Appointment Confirmations:_____

Dental Insurance Information

Insured's Name_____ Insured's Social Security #_____

Relationship to Patient:_____

Insurance Company_____ Group No._____ ID No. _____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_____ Insured's Social Security #_____

Insurance Company_____ Group No._____ ID No. _____

Emergency Information

Name of nearest relative not living with you _____

Complete address_____
Street City Zip

Phone _____

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

Signature (Parent's signature if minor) _____

Updates (date & initial)_____

LIKE OUR FACEBOOK TO COMMUNICATE AND STAY IN THE KNOW ON UPDATES AND EXCITING THINGS WE HAVE GOING ON IN OUR OFFICE.

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____
Please circle Yes or No **(If Yes, please fill in details)**

Yes No Are you taking any medication? If yes, list for what: _____
Yes No Are you allergic to any medication? _____
Yes No Do you have a latex allergy?_____
Yes No Do you have a history of a major illness? _____
Yes No Have you had any major operations? _____
Yes No Have you ever been involved in a serious accident? _____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous/Mental Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

DENTAL HISTORY

Dentist _____ Date of last visit _____
Is there further treatment to be completed?_____ Date of next visit?_____
What concerns you most about your teeth? _____

Yes No Are you presently in any dental pain? _____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
Yes No Have you ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth or teeth? _____
Yes No Is any part of your mouth sensitive to temperature or pressure? _____
Yes No Do your gums bleed when you brush? _____
Yes No Do you have any type of thumb or tongue habit? _____
Yes No Are you a mouth breather? _____
Yes No Have you ever seen an orthodontist? If yes, who and when? _____
Yes No Would you object to wearing orthodontic appliances (braces) should they be indicated? _____
Yes No Has anyone in your family received orthodontic treatment? _____
How did they feel about the result? _____
What is your attitude toward receiving orthodontic treatment? _____
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
Yes No Are you aware of your jaw clicking or popping? _____
Yes No Are you aware of clenching your teeth during the day? _____
Yes No Have you ever been told that you grind your teeth? _____
Yes No Do you have “tension” headaches? _____
Yes No Have you ever experienced chronic ringing in your ears? _____
Yes No If the patient is under age 16, height of parents? Mom_____ Dad_____
Yes No Are you aware that some appointments will be during school/work hours? _____
Please list some hobbies or interests _____
Yes No Female patients only: Are you pregnant? _____
Yes No Has menstruation started? _____ If so When _____
Yes No Have you heard of Invisalign? _____ If so, would you be interested? _____

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 the 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 our lifetime and there can be some movement of teeth 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. Christy D Head and Dr. Sarah B. Kimbrough to perform a complete orthodontic evaluation.

Signature: _____ Date: _____