Stotts Orthodontics

PATIENT INFORMATION

NAME: (last)_____ (first)_____ (mi) _____ (nickname) _____

PREFERRED PRONOUNS (If Applicable) _____

ADDRESS: _____ City: _____ State: _____ Zip: ____

PHONE: _____ BIRTH DATE: _____ /_____ /_____ AGE: _____

E-MAIL ADDRESS: _____ GENDER _____

HOW DID YOU HEAR ABOUT OUR OFFICE?

- ☐ Web Search (Google, Bing, etc.)
- ☐ Reviews Site (Yelp, Angies List, etc.)
- ☐ Dentist Referral
- ☐ Personal Referral
- ☐ Saw Advertising Online
- ☐ I Knew From Community Activities (Sponsorships, Charity, etc.)
- ☐ Insurance
- ☐ Radio

☐ Other: Please Explain _____

SCHOOL YOU ATTEND: _____

RESPONSIBLE PARTY INFORMATION **(The person signing the contract will be the responsible party)**

NAME (last, first, mi):_____ MARITAL STATUS: _____

ADDRESS (if different): _____

HOME PHONE # (if different): _____

EMPLOYER: _____

WORKED FOR HOW LONG:_____ WORK PHONE #: _____

FAMILY INFORMATION **(please complete only if patient is a minor)**

FATHER'S NAME: _____ MOTHER'S NAME: _____

E-MAIL ADDRESS _____ E-MAIL ADDRESS _____

ADDRESS (if different) _____ ADDRESS _____

PHONE #: _____ PHONE #: _____

BUSINESS PHONE #:_____ BUSINESS PHONE #: _____

DENTAL INSURANCE INFORMATION

NAME OF INSURANCE:_____

INSURANCE ADDRESS: _____

City: _____ State_____ Zip ____

INSURANCE PHONE #: _____ GROUP #:_____

NAME OF INSURED AND BIRTH DATE: _____ SSN# _____

INSURED ID#: _____ NAME OF EMPLOYER: _____

IF THERE IS A SECONDARY INSURANCE PLEASE ASK FOR ANOTHER FORM. THANKS

EMERGENCY INFORMATION

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU: _____

ADDRESS: _____

PHONE #: _____ RELATIONSHIP:_____

MEDICAL HISTORY

PATIENT NAME:

PHYSICIAN'S NAME_____

HAS PATIENT HAD ANY OF THE FOLLOWING (PLEASE MARK BOX) _____

- ☐ HEART PROBLEMS/MURMUR
- ☐ HIGH BLOOD PRESSURE
- ☐ ARTIFICIAL HEART VALVES OR JOINTS
- ☐ DIABETES
- ☐ RESPIRATORY DISEASE
- ☐ EPILEPSY
- ☐ HEADACHES
- ☐ HEPATITIS LIVER DISEASE
- ☐ EMOTIONAL DISORDERS
- ☐ ALLERGIES TO MEDICINE
- ☐ GENERAL ALLERGIES
- ☐ TONSILLITIS
- ☐ AIDS (-UTOIMMUNE DISEASES)
- ☐ VENEREAL DISEASE
- ☐ HEMOPHILIA (BLEEDING DISORDERS)
- ☐ RHEUMATIC FEVER
- ☐ RECENT UNEXPECTED WEIGHT LOSS
- ☐ OTHER, SPECIFY_____

PRESENT STATE OF HEALTH: ☐ **EXCELLENT** ☐ **GOOD** ☐ **POOR**

IS PATIENT TAKING MEDICINE AT THIS TIME? ☐ **YES** ☐ **NO** IF SO, WHAT _____

_____

IS PATIENT PRESENTLY UNDER PHYSICIAN'S CARE? ☐ **YES** ☐ **NO** WHAT CONDITION_____

IF PATIENT IS A CHILD WHAT IS HIS/HER WEIGHT?_____ HEIGHT _____

IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT YOUR MEDICAL HISTORY? _____

REVIEWED_____ DATE _____

DENTAL HISTORY

NAME OF YOUR DENTIST: _____

HAS PATIENT HAD ANY OF THE FOLLOWING? (PLEASE MARK BOX)

- ☐ RECENT DENTAL X-RAYS
- ☐ TEETH CLEANED RECENTLY
- ☐ FLUORIDE TREATMENT
- ☐ PREVIOUS ORTHODONTIC CONSULTATION
- ☐ PERIODONTAL TREATMENT
- ☐ RECENT FILLINGS, CROWNS
- ☐ TRAUMA TO FACE/MOUTH
- ☐ IMPRESSIONS
- ☐ DENTAL CHECK UP
- ☐ TMJ SPLINT

WHAT DO YOU CONSIDER THE MAIN BENEFIT OF ORTHODONTIC TREATMENT? ☐ **FUNCTIONAL** ☐ **COSMETIC** ☐ **PSYCHOLOGICAL**

IS PATIENT SELF-CONSCIOUS OF HIS/HER TEETH? ☐ **YES** ☐ **NO**

HAVE WE TREATED OTHERS IN YOUR FAMILY? ☐ **YES** ☐ **NO** WHO_____

AS A PART OF TREATMENT, IF YOUR CHILD MAY BENEFIT FROM HAVING TEETH REMOVED AND/OR JAW SURGERY, WOULD YOU PREFER WE DISCUSSED WITH YOUR CHILD? ☐ **YES** ☐ **NO**

DOES PATIENT HAVE PAST/PRESENT HISTORY OF:

- ☐ TONGUE THRUST
- ☐ THUMB SUCKING
- ☐ FINGER SUCKING
- ☐ NAIL BITING
- ☐ MOUTH BREATHING
- ☐ SPEECH IMPEDIMENT
- ☐ TMJ
- ☐ POPPING, CLICKING IN JAW JOINT

THIS FORM WAS COMPLETED BY: (CIRCLE) PATIENT PARENT GUARDIAN

SIGNATURE:_____ DATE: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE PRIVACY PRACTICES

I, _____ have received a copy of this offices Privacy Practices.

_____

Please Print Name

_____

Signature and Date