WELCOME TO CASSALIA ORTHODONTICS

PLEASE FILL OUT THE FORM COMPLETELY. THE BETTER WE COMMUNICATE, THE BETTER WE CAN SERVE YOU.

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

1 ABOUT YOU

Todays Date:_____

Name:_____
LAST FIRST MI MR MRS MS DR

I Prefer To Be Callec:_____ Male Femal e

Birthcate:__/__/__ Age:____ SS#:_____

Home Accress:_____ APT/CONDO #
City State Zip

Email Accress:_____

Single Marrie d Divorce d Widowe d Separated

Home #:_____ Cell/Other #:_____

Work #:_____ EXT:_____ DL#:_____

Employer:_____

Employer Accress:_____

_____

How long there?:_____ Occupation:_____

Whom may we thank for referring you?:_____

Other family members seen by us:_____

_____

2 SPOUSE INFORMATION

His / Her Name:_____

Employer:_____

Work#:_(___)_____EXT_____SS#_____

Birthcate:__/__/__

Email Accress:_____

3 Person Responsible for Account

His / Her Name:_____

Work#:_(___)_____EXT_____Home #_____

Billing Accress:_____

_____

Relation:_____ SS#:_____

Employer:_____

Drivers license #:_____

4 ORTHODONTIC INSURANCE

Primary

Orthocontic Coverege: ☐ Yes ☐ No

Dental Coverege: ☐ Yes ☐ No

Insurance Co. Name:_____

Insurance Co. Ac cress:_____

Insurance Co. Phone #:_(___)_____

Group # (Plan, Local or Policy #:_____

Insurec's Name:_____

Relation:_____

Insurec's Birthcate:___/___/___ Insurec's ID#_____

Insurec's Employer:_____

Secondary

Orthocontic Coverege: ☐ Yes ☐ No

Dental Coverege: ☐ Yes ☐ No

Insurance Co. Name:_____

Insurance Co. Ac cress:_____

Insurance Co. Phone #:_(___)_____

Group # (Plan, Local or Policy #:_____

Insurec's Name:_____

Relation:_____

Insurec's Birthcate:___/___/___ Insurec's ID#_____

Insurec's Employer:_____

5 Medical History

Your current physical Health is: ☐ Gooc ☐ Fair ☐ Poor

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

Please Explain:_____

Physician Name:_____

Are you takinc any prescription/ over-the counter crucs?

☐ Yes ☐ No

Please list each one:

_____

_____

Are you allergic to an of the following?

Dental Anesthetics	☐ Yes	☐ No
Erythromycin	☐ Yes	☐ No
Latex	☐ Yes	☐ No
Penicillin	☐ Yes	☐ No
Tetracycline	☐ Yes	☐ No
Asprin	☐ Yes	☐ No
Any Metals/ Plastics	☐ Yes	☐ No
Coceine	☐ Yes	☐ No
Other	☐ Yes	☐ No

Please list any other crucs/materials that you are allercic:

_____

For Women:

Are you usinc a prescribec methoc of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week#_____

Are you nursinc? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Abnormal Bleeding	☐ Yes	☐ No		Hemophilia	☐ Yes	☐ No	
Anemia	☐ Yes	☐ No		Hepatitis	☐ Yes	☐ No	
Artificial Bones / Joints / Valves	☐ Yes	☐ No		High / Low Blood Sugar	☐ Yes	☐ No	
Asthma	☐ Yes	☐ No		HIV +/ AIDS	☐ Yes	☐ No	
Arthritis	☐ Yes	☐ No		Hospitalized For Any Reason	☐ Yes	☐ No	
Blood Transfusion	☐ Yes	☐ No		Kidney Problems	☐ Yes	☐ No	
Cancer / Chemotherapy	☐ Yes	☐ No		Mitral Valve Prolapse	☐ Yes	☐ No	
Congenital Heart Defect	☐ Yes	☐ No		Psychiatric Problems	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No		Radiation Treatment	☐ Yes	☐ No	
Difficulty Breathing	☐ Yes	☐ No		Rheumatic / Scarlet Fever	☐ Yes	☐ No	
Drug / Alcohol Abuse	☐ Yes	☐ No		Severe/ Frequent Headaches	☐ Yes	☐ No	
Emphysema	☐ Yes	☐ No		Shingles	☐ Yes	☐ No	
Epilepsy / Seizures / Fainting	☐ Yes	☐ No		Sickle Cell Disease / Traits	☐ Yes	☐ No	
Fever Blisters / Herpes	☐ Yes	☐ No		Sinus Problems	☐ Yes	☐ No	
Glaucoma	☐ Yes	☐ No		Tuberculosis (TB)	☐ Yes	☐ No	
Heart Attack / Stroke	☐ Yes	☐ No		Ulcers / Colitis	☐ Yes	☐ No	
Heart Murmur	☐ Yes	☐ No		Venereal Disease	☐ Yes	☐ No	
Heart Surgery / Pacemaker	☐ Yes	☐ No					

Please list any serious medical conditions that you ever had:

_____

_____

6 Dental History

What is the main concern that you would like orthodontics to accomplish?

_____

_

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 your gums ever bleed? ☐ Yes ☐ No

Have you ever had an injury to your: ☐ Mouth ☐ Teeth ☐ Chin

Do you have any speech problems? ☐ Yes ☐ No

Do you generally breath through your Mouth ☐ Yes ☐ No

Do you have any missing or extra permanent teeth? ☐ Yes ☐ No

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

THANK YOU FOR FILLING OUT THIS FROM COMPLETELY.

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 it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary services that I may need during diagnosis and treatment with my informed consent.

Full Name _____ Date _____

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.

Full Name _____ Date _____

If this office accepts your 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 directly to this office. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Full Name _____ Date _____