DATE_____

Patient No:_____

ORTHODONTIC PATIENT INFORMATION

WELCOME TO OUR OFFICE

The following information is requested to enable us to give you the best consideration of your orthodontic problem during your initial examination in our office. In order for the orthodontist to thoroughly diagnose any condition, he must have accurate background and health information on which to base his decisions. This information, important for your health, is confidential. Please circle the appropriate responses where indicated.

PATIENT INFORMATION

Name:_____

Address:_____

City:_____

State:_____Zip:_____

Home Ph:_____Cell Ph:_____

Social Security#:_____

Birthdate:_____Age:_____

Sex:_____Marital Status:_____

Occupation/Name of School:_____

Teacher:_____Grade:_____

Employer:_____

Business Phone:_____

Family Dentist:_____

How did you hear about our office?_____

Family Physcian:_____

FAMILY STATUS

Patient Living with:_____

Father's Name:_____

Mother's Name:_____

Siblings: None ____Number Brothers____Number Sisters

INSURANCE INFORMATION

Is patient covered by dental or orthodontic insurance?

Lifetime Max.:_____Percent Payable:_____

Policy Holder:_____

Policy Holders Social Security #:_____

Employer:_____

Address:_____

Birthdate:_____Relation to Patient:_____

Name of Ins. Co.:_____

Address:_____

Group No.:_____Contract No.:_____

Occasionally information is shared with a family dentist or other specialists. By providing us your email address, we can share this information with you.

email:_____

PERSON RESPONSIBLE FOR ACCOUNT

Name:_____

Street Address:_____

City:_____State:_____Zip_____

How long at this address?_____

Previous Address (if less than 2 years):_____

Home Ph.:_____Cell Ph.:_____

May we call you at your job?___WorkPh:_____

Driver's License No:_____

Social Security No.:_____

Birthdate:_____Relation to Patient:_____

Marital Status:_____Sex:_____

Employer:_____

Occupation:_____No. Years Employed:_____

Address:_____

SPOUSE/OTHER PARENT INFO

Name:_____

Address:_____

City:_____State:_____Zip:_____

Home Phone:_____Work Phone:_____

May we call your job?_____Cell Ph.:_____

Relationship to Patient:_____

Employer:_____

Occupation:_____No Years Employed:_____

Address:_____

Social Security No.:_____

Birthdate:_____

SECOND INSURANCE CARRIER INFORMATION

Second Policy Holder:_____

Policy Holders Soc. Sec. No.:_____

Employer:_____

Address:_____

Birthdate:_____Relation to Patient:_____

Name of Ins. Co.:_____

The following conditions are of interest to the Orthodontist.
Has the patient ever had?

Arthritis	Diabetes	Hearing Disorder
Asthma	Epilepsy	Head or Face Injury
Anemia	Endocrine Problems	Hepatitis
Blood Disease (ANY BLEEDING DISORDERS)	Emotional Problems	Respiratory Problems
Bone Disorders	Glaucoma	Rheumatic Fever
Cancer (ANY FORM)	Heart Disease (ANY KIND)	Venereal Disease(s)
		Acquired Immune Deficiency Syndrome

None of the Above_____
ANY OTHER MEDICAL INFORMATION RELEVANT_____

PATIENTS MEDICAL AND DENTAL HISTORY

Present health: GOOD FAIR POOR Does the patient have any birth defects? YES NO
Under treatment:_____ Specify:_____
Presently taking medication: YES NO Patient reached puberty (menstruation, hair) YES NO
Specify:_____
Are you taking or have you ever taken Bisphosphonates? YES NO
Have you ever been told you have sleep apnea?_____
Are you under treatment for sleep apnea ? _____
Do you have any artificial joints? YES NO When:_____
Has patient been under physician's care during the past two years other than routine exams? YES NO
Does the patient:

1. Have allergies to : Seasonal grasses_____Food:_____
   Drugs:_____ Other:_____
2. Snore when sleeping? YES NO
3. Breath through mouth? SELDOM SOMETIMES USUALLY COMMENTS:_____
4. Have frequent sore throats or tonsillitis? YES NO
5. Does patient smoke? YES NO Do Parents Smoke? NO **IF YES**: MOTHER FATHER SPOUSE
6. Have chewing or swallowing difficulty? YES NO

Has the patient received medical treatment from allergist or ear, nose and throat specialist?
YES NO **IF YES** When: _____By Whom:_____

Tonsils removed :_____ _____Adenoids removed: _____
_____ Does the patient have pain or clicking in jaw joint? YES NO When started:_____
_____ Have teeth been injured due to accidents or blows to the mouth? YES NO Date:_____
Has the patient received or been requested to receive speech correction? YES NO Date:_____
Thumb sucking until age :_____Grinding teeth? YES NO
Finger sucking until age: _____Tongue thrusting? YES NO
Lip biting or sucking YES NO Other habits YES NO
Has patient had any unusual dental experiences?
Specify:_____
Does patient wear contact lenses? YES NO
Are there any other medical, dental, or surgical problems not covered above? YES NO

PATIENTS ATTITUDE TOWARD TEETH, FACE AND ORTHODONTIC TREATMENT:

Dental checkups: Twice A Year Once A Year Only If Urgent Never
Date of last dental checkup_____ Were the patient's teeth cleaned? YES NO
Is the patient aware of any orthodontic problem? YES NO Are there any untreated or active cavities YES NO
Has the patient visited another orthodontist? YES NO Name:_____Date:_____
Patient's interest in orthodontic treatment :
Patient Wants Treatment Treatment If Necessary Unwilling But Agrees Uncooperative
Orthodontic consultation prompted by: Patient Dentist Mother Father Spouse Sibling
Physician Friend Other (specify)_____
Why did the patient seek this consultation?_____
What is the CHIEF COMPLAINT?_____
What is expected from orthodontic treatment?_____
Additional comments you wish to make:_____

I understand that where appropriate, credit bureau reports may be obtained.
I authorize release of any information relating to my insurance claim. I understand that I am responsible for all costs of orthodontic treatment.
I hereby authorize payments of insurance benefits otherwise payable to me, directly to Dr. Kurshuk.

PATIENT SIGNATURE (PARENT/GUARDIAN IF PATIENT IS A MINOR):_____

RELATIONSHIP TO PATIENT:_____TODAY'S DATE:_____