ORDAHL ORTHODONTICS

Thank You for Coming to our Practice!

The information below is requested in order to completely and accurately diagnose any condition and evaluate your orthodontic needs. This information entrusted to us is CONFIDENTIAL.

Patient Information

Patient's Name: _____ Date of Birth: ____/____/_____ Age: _____ Sex: _____

Address: _____ City/State/Zip: _____ Home Phone: _____

Patient's Email Address: _____Cell Phone: _____

Referred by: _____

Patient's Physician: _____ Phone: _____

Patient's Dentist: _____ Date of Last Cleaning: ____/____/_____ Phone: _____

Patient's Height: _____ Father's Height: _____ Mother's Height _____ Adopted (Y or N) _____

Patient lives with: _____ Phone: _____

Nearest relative not living with patient: _____ Phone: _____

Emergency Contact: _____ Relation: _____ Home Phone: _____Cell Phone: _____

Financial Information

Title: Mr. & Mrs. ____ Mr. ___ Dr. ___ Ms. ___ Miss ____ Email Address: _____

Responsible Party's Name: _____ Phone: _____

Social Security Number: _____ Date of Birth: _____/_____/_____ Relationship to Patient: _____

Address: _____ City/State/Zip: _____ Phone: _____

Employer: _____ Title: _____ Work Phone: _____

Address: _____ City/State/Zip: _____

Insurance Information

Do you have dental or orthodontic insurance? Yes _____ No_____ (If yes, please complete section below)

Primary Insurance Carrier: _____ Phone: _____ Group Number: _____

Claims Address: _____ City/State/Zip: _____

Policy Holder _____Date of Birth: _____/_____/_____ SSN: _____ Employer: _____

Secondary Insurance Carrier: _____ Phone: _____ Group Number: _____

Claims Address: _____ City/State/Zip: _____

Policy Holder _____Date of Birth: _____/_____/_____ SSN: _____Employer: _____

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Please answer each question. Circle YES or NO where applicable.

Medical History

1. Is the patient in good health? YES NO
2. Any history of Illness? YES NO
3. Has the patient ever been treated for the following:

Heart Problems_____	Tuberculosis_____	Epilepsy _____
Diabetes _____	Asthma_____	Prolonged Bleeding _____
Pneumonia _____	Anemia _____	Endocrine Problems _____
Thyroid Disorders_____	Stomach Problems _____	Rheumatic Fever _____
Liver Disorders_____	Bone Disorders _____	Kidney Disorders _____
Mental Illness _____	Skin Disorders _____	Dizziness _____

Other _____

4. Does the patient have a history of frequent:
   Colds _____ Sore Throats _____ Ear Infections _____Headaches_____
5. Has the patient ever been exposed to: Herpes _____ AIDS _____ Hepatitis _____
6. Has the patient's tonsils and adenoids been removed? YES NO If so, what age: _____
7. *Girls Only*: Has the patient started her monthly period? YES NO If so, what age: _____
   Is the patient pregnant? YES NO
8. Is the patient currently under medical treatment? YES NO If yes, for what condition _____
9. List any drugs or medications taken: _____
10. List any allergies or drug sensitivities: _____

Dental History

1. Are there other family members with similar orthodontic conditions? YES NO If so, who? _____
2. Has the patient had any unusual dental experiences? YES NO If yes, explain _____
3. Does the patient want their teeth straightened? YES NO
4. Have their ever been any injuries to the face or mouth? YES NO If yes, explain_____
5. Does the patient have any periodontal (gum) problems? YES NO
6. Has the patient ever sucked a thumb or finger? YES NO If yes, until what age _____
7. Does the patient swallow abnormally (tongue thrust)? YES NO
8. Does the patient have a history of speech problems? YES NO
9. Does the patient breathe through the mouth while awake? YES NO or while asleep? YES NO
10. Have you ever been informed of any missing teeth? YES NO
11. Have you ever been informed of any extra teeth? YES NO
12. Does the patient have any jaw popping and/or pain? YES NO Frequent headaches? YES NO
13. Does the patient have difficulty chewing or jaw opening? YES NO
14. Does the patient clench or grind his or her teeth at night? YES NO
15. Have you previously consulted an orthodontist? YES NO
16. Has the patient had previous orthodontic treatment? YES NO
    If yes, name of orthodontist _____

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Miscellaneous Information

1. Are you aware that some appointments may be schedule during school time? YES NO
2. When being notified for appointment reminders, would you like to be contacted via text message? YES NO
3. Please give a brief description of the reasons for your visit _____
   _____

PLEASE READ THIS PARAGRAPH CAREFULLY AND SIGN BELOW

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made to this form. I have fully completed this form and certify that I am the patient or duly authorized agent of the patient authorized to furnish the information requested. If there are any changes in the future to the medical or dental history of the patient, I will inform this practice. I understand that even if the patient has orthodontic coverage, I am still fully responsible for all financial agreements and treatment fees. I further agree to pay any collection agency costs or legal fees associated with the collection of any fees that should become delinquent on my account. I grant my permission to you or your staff, to contact me at home or at my work to discuss matters related to this form, fees, and treatment of the patient. I have read the above conditions and agree to their consent.

Signed: _____ Date: _____

DO NOT WRITE BELOW – FOR OFFICE USE ONLY

Exam Notes: _____
_____
_____
_____
_____
_____

Phase: One Two
Banding: Upper Lower Both
Retainer Only: Yes No
Mouth Guard: Yes No

Treatment Cost:

- Initial Appliance Fee: _____
- Banding Fee: _____
- Down Payment: _____
- Monthly Payment: _____ for approx. _____ months