CD Orthodontics

Date_____ **Adult Patient Information (Please Print)**

Name _____ Date of Birth _____

Address

_____

Street Apt # City State Zip

Cell Phone (____) _____ Work Phone (____) _____

Email _____

Who referred you to us? _____

Child Patient Information (Please Print)

Name _____ Date of Birth _____

Father/Guardian _____ Email _____

Address

_____

Street Apt # City State Zip

Cell Phone (____) _____ Work Phone (____) _____

Mother/Guardian _____ Email _____

Address

_____

Street Apt # City State Zip

Cell Phone (____) _____ Work Phone (____) _____

Who referred you to us? _____

Financial Responsible Party (Required)

Name _____ Email _____

Address

_____

Street Apt # City State Zip

Cell Phone (____) _____ Work Phone (____) _____

For Dental Insurance Only

Primary Insurance Dental Coverage ☐ Yes ☐ No Orthodontic Coverage ☐ Yes ☐ No

Insurance Co. Name _____ Phone _____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____ Relationship _____

Policy Owner's Date of Birth _____ Social Security # or Subscriber ID # _____

Address_____

Policy Owner's Employer's Name _____

Secondary Insurance Dental Coverage ☐ Yes ☐ No Orthodontic Coverage ☐ Yes ☐ No

Insurance Co. Name _____ Phone _____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____ Relationship _____

Policy Owner's Date of Birth _____ Social Security # or Subscriber ID # _____

Address_____

Policy Owner's Employer's Name _____

I authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges, regardless of coverage.

Signature _____ Date _____

Orthodontic Concerns

1. What are your orthodontic concerns for today's visit? _____
2. Other concerns ☐ Teeth ☐ Jaw ☐ Face ☐ Lip ☐ Profile ☐ Gum Line ☐ Esthetics ☐ Others _____
3. Are you interested in ☐ Traditional Braces ☐ Clear Braces ☐ Invisalign ☐ Retainers ☐ Others _____

Medical History

1.	Are you in good health?	☐ Yes ☐ No
2.	Are you allergic to latex?	☐ Yes ☐ No
3.	Are you allergic to metal?	☐ Yes ☐ No
4.	Are you taking any medication for Osteoporosis, Bone density or Estrogen replacement?	☐ Yes ☐ No
5.	Do you have excessive bleeding?	☐ Yes ☐ No
6.	Do you have Hepatitis B or C?	☐ Yes ☐ No
7.	(Women) Are you pregnant?	☐ Yes ☐ No
8.	Do you have any history of heart trouble, allergies, diabetes, asthmas, hepatitis, kidney, or liver involvement, epilepsy, or bleeding disorders?	☐ Yes ☐ No
9.	Do you have a cerebral condition or mental imbalance?	☐ Yes ☐ No
10.	Have you ever experienced any unfavorable reaction to medicine?	☐ Yes ☐ No
	Such as: penicillin, aspirin, or Novocain? (Specify in line 13)	☐ Yes ☐ No
11.	Do you take any drugs or medications regularly? (Specify in line 13)	☐ Yes ☐ No

12. Who is your Medical Doctor? _____ Phone _____
13. Is there anything medical we should know about you that would adversely affect orthodontic treatment?

_____

_____

Allergies _____ Medications _____ Last visit MD _____

_____

Emergency Contact Information

In case of emergency, please contact _____ Phone _____

Relationship to patient _____

Dental History

1.	Do you have periodontal diseases?	☐ Yes ☐ No
2.	Have you had a facial injury in the past?	☐ Yes ☐ No
3.	Do you have TMJ symptoms?	☐ Yes ☐ No
4.	Do you have any oral habits such as tongue thrust or thumb sucking?	☐ Yes ☐ No
5.	Do you have speech problems, mouth breathing habits, or grinding?	☐ Yes ☐ No
6.	Do you play a wind-musical instrument?	☐ Yes ☐ No
7.	Have you had any orthodontic treatment in the past?	☐ Yes ☐ No
8.	Do you have family members who had orthodontic treatment?	☐ Yes ☐ No

9. Who is your Dentist? _____ Phone _____
10. (Adolescent girl) To estimate growth, indicate age when you started your menstrual period _____
11. (Adolescent boy) To estimate growth indicate age when you had the most growth in height _____
12. Is there anything medical we should know about you that would adversely affect orthodontic treatment?

_____

Periodontal conditions _____ Last visit DDS _____ Last dental cleaning _____

_____

Signature _____ Date _____

Thank you for choosing CD Orthodontics for your orthodontic needs. We will take the best care of your Smile!