Pryor Orthodontics

Adult

Date: _____

Thank you for selecting our orthodontic health care team! We will strive to provide you with the best possible orthodontic care. To help us meet all of your needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

PATIENT INFORMATION – Please Print (Confidential)

Dr./Mr. Mrs./Ms. _____ (First / Last / M.I.) Age: _____ Date of Birth:_____ /_____ /_____

Home Address: _____City:_____ State: _____ Zip: _____ Phone: (_____) _____

Business Address: _____City:_____ State: _____ Zip: _____ Phone: (_____) _____

Mobile/Cell Phone: (_____) _____ Email Address:_____

Person to Contact in Case of Emergency:_____ Relationship: _____ Phone:(_____) _____

Name of Dentist:_____ Phone: (_____) _____

How long have you been a patient at above:_____ Date of Last Dental Check-up: _____

Referred By: ❑Friend: _____ ❑Dentist ❑Yellow Pages ❑Other: _____

Your marital status: ❑Single ❑Married ❑Widow(er) ❑Divorced

Have you had any previous orthodontic treatment or orthodontic consultations? ❑Yes ❑No ❑If yes, when?

If so, where?_____ What were you told?_____

What is/are your main concern(s) about your teeth? _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account: _____ Relationship to Patient: _____

Address: _____City:_____ State: _____ Zip: _____ Phone: (_____) _____

Driver's License # :_____ Date of Birth: _____ /_____ /_____ SSN: _____-_____-_____

Employer: _____ Address: _____ Phone: (_____) _____

Is this person currently a patient in our office? ❑Yes ❑No

INSURANCE INFORMATION

Do you or billing party have Orthodontic Insurance? ❑Yes ❑No ❑Not Sure

If yes, Name of Insured: _____ Date of Birth: _____ /_____ /_____ SSN of Insured: _____-_____-_____

Insurance Company Carrying Policy: _____ Group#: _____ Union or Local #:_____

Name of Insured (Secondary):_____ Date of Birth: _____ /_____ /_____ SSN of Insured: _____-_____-_____

Insurance Company Carrying Policy: _____ Group#: _____ Union or Local #:_____

FAMILY INFORMATION

Children: Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Have any family members been previously treated at our offices: ❑Yes ❑No

Name: _____Dates: _____ Office:_____

Name: _____Dates: _____ Office:_____

Please bring your insurance information to the office at your first visit.

PATIENT MEDICAL HISTORY

Physician: _____ Office Phone: (_____) _____ Date of Last Exam:_____ /_____ /_____

1. Are you under medical treatment now? ❑Yes ❑No

2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? ❑Yes ❑No

If yes, please explain: _____

_____

3.Are you taking any medication(s) including non-prescription medicine? ❑Yes ❑No

If yes, please explain: _____

_____

4. Have you ever taken Phen-Fen/Redux? ❑Yes ❑No

5. Do you use tobacco? ❑Yes ❑No

6. Do you use controlled substances? ❑Yes ❑No

7. Are you wearing contact lenses? ❑Yes ❑No

8. Are you allergic to or have they had any reaction to the following:

Local anesthetic (e.g. Novocaine)	❑Yes	❑No
Penicillin or any Antibiotics	❑Yes	❑No
Sulfa Drugs	❑Yes	❑No
Barbiturates	❑Yes	❑No
Sedatives	❑Yes	❑No
Iodine	❑Yes	❑No
Aspirin	❑Yes	❑No
Any Metals (e.g. nickel, mercury, etc.)	❑Yes	❑No
Latex Rubber	❑Yes	❑No

Other (please list): _____

_____

9. Women only:
   a) Are you pregnant or think you may be pregnant? ❑Yes ❑No
   b) Are you nursing? ❑Yes ❑No
   c) Are you taking oral contraceptives? ❑Yes ❑No

Does patient have or have they had any of the following:

High Blood Pressure	❑Yes	❑No	Cardiac Pacemaker	❑Yes	❑No	Easily Winded	❑Yes	❑No
Heart Attack	❑Yes	❑No	Heart Murmur	❑Yes	❑No	Stroke	❑Yes	❑No
Rheumatic Fever	❑Yes	❑No	Angina	❑Yes	❑No	Hay Fever/Allergies	❑Yes	❑No
Swollen Ankles	❑Yes	❑No	Frequently Tired	❑Yes	❑No	Tuberculosis	❑Yes	❑No
Fainting/Seizures	❑Yes	❑No	Anemia	❑Yes	❑No	Radiation Therapy	❑Yes	❑No
Asthma	❑Yes	❑No	Emphysema	❑Yes	❑No	Glaucoma	❑Yes	❑No
Low Blood Pressure	❑Yes	❑No	Cancer	❑Yes	❑No	Recent Weight Loss	❑Yes	❑No
Epilepsy/Convulsions	❑Yes	❑No	Arthritis	❑Yes	❑No	Liver Disease	❑Yes	❑No
Leukemia	❑Yes	❑No	Joint Replacement or Implant	❑Yes	❑No	Heart Trouble	❑Yes	❑No
Diabetes	❑Yes	❑No	Hepatitis/Jaundice	❑Yes	❑No	Respiratory Problems	❑Yes	❑No
Heart Disease	❑Yes	❑No	Chest Pains	❑Yes	❑No	Mitral Valve Prolapse	❑Yes	❑No

PATIENT DENTAL HISTORY

Name of present dentist and location: _____ Date of Last Exam:_____ /_____ /_____

1. Do your gums bleed while brushing or flossing? ❑Yes ❑No
2. Are teeth sensitive to hot or cold liquids/foods? ❑Yes ❑No
3. Are teeth sensitive to sweet or sour liquids/foods? ❑Yes ❑No
4. Do you feel pain to any teeth? ❑Yes ❑No
5. Have you had any sores or lumps in or near mouth? ❑Yes ❑No
6. Have you had any head, neck or jaw injuries? ❑Yes ❑No
7. Have you ever experienced any of the following problems with their jaw:
   a) Clicking ❑Yes ❑No
   b) Pain [joint, ear, side of face] ❑Yes ❑No
   c) Difficulty in opening or closing ❑Yes ❑No
   d) Difficulty in chewing ❑Yes ❑No
8. Doe you have frequent headaches? ❑Yes ❑No
9. Do you clench or grind teeth? ❑Yes ❑No
10. Do you bite lips or cheeks frequently? ❑Yes ❑No
11. Have you ever had difficult extractions? ❑Yes ❑No
12. Have you ever had any prolonged bleeding? ❑Yes ❑No
13. Have you ever had any orthodontic treatment? ❑Yes ❑No
14. Do you require antibiotics for dental treatment? ❑Yes ❑No
15. Have you ever received oral hygiene instructions regarding care of teeth/gums? ❑Yes ❑No
16. Do you like your smile? ❑Yes ❑No

AUTHORIZATION & RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to patient's health. I authorize Pryor Orthodontics to release any information including the diagnosis and the records of any treatment or examination rendered to the patient during the period of such orthodontic care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to Pryor Orthodontics any insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

X_____

Signature of Patient/Responsible Party Relationship to Patient

Doctor's Comments:

_____

_____

_____

_____

_____

Signature: _____ Date: _____

Pryor Orthodontics