Pryor Orthodontics

Under 18

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)

Name: _____ (First / Last / M.I.) Gender: Male Female

Age: _____ Date of Birth: ____/____/____ Home Phone: (____)_____ Cell/Mobile Phone:(____)_____

Home Address: _____City:_____ Zip: _____E-mail: _____

Patient's School: _____ Grade: _____ Hobbies: _____

Person to Contact in Case of Emergency:_____

Relationship: _____ Phone: (_____) _____

Name of Dentist:_____ Phone: (_____) _____

How long has he/she been a patient at above: _____ Date of Last Dental Check-up: _____

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

Does the patient play a musical instrument? _____ Engage in contact sports? _____

Has patient had any previous orthodontic treatment or orthodontic consultations? ❑Yes ❑No ❑If yes, when? _____

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

What is/are main concern(s) about the patient's teeth? _____

FAMILY INFORMATION

Father's Name: _____ Address: _____ City: _____ State: _____Zip: _____

Father's Employer: _____ Occupation: _____ Work Phone: (_____) _____

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

Mother's Name: _____ Address: _____ City: _____ State: _____Zip: _____

Mother's Employer: _____ Occupation: _____ Work Phone: (_____) _____

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

Have any family members been previously treated at our offices: Yes No Names/Offices:

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: (_____) _____

INSURANCE INFORMATION

Does patient have Orthodontic Insurance coverage? ❑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 #:_____

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

PATIENT MEDICAL HISTORY

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

1. Is patient under medical treatment now? ❑Yes ❑No
2. Has patient ever been hospitalized for any surgical operation or serious illness within the last 5 years? ❑Yes ❑No

If yes, please explain: _____

_____

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

If yes, please explain: _____

_____

4. Has patient ever taken Phen-Fen/Redux? ❑Yes ❑No
5. Does patient use tobacco? ❑Yes ❑No
6. Does patient use controlled substances? ❑Yes ❑No
7. Is patient wearing contact lenses? ❑Yes ❑No
8. Is patient 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) Is patient pregnant or think she may be pregnant?
   b) Is patient taking oral contraceptives?

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

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PATIENT DENTAL HISTORY

Name of patient's dental and location: _____ Date of Last Exam:_____ /_____ /_____

1. Do patient's 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. Does patient feel pain to any teeth? ❑Yes ❑No
5. Has patient had any sores or lumps in or near mouth? ❑Yes ❑No
6. Has patient had any head, neck or jaw injuries? ❑Yes ❑No
7. Has patient 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. Does patient have frequent headaches? ❑Yes ❑No
9. Does patient clench or grind teeth? ❑Yes ❑No
10. Does patient bite lips or cheeks frequently? ❑Yes ❑No
11. Has patient ever had difficult extractions? ❑Yes ❑No
12. Has patient ever had any prolonged bleeding? ❑Yes ❑No
13. Has patient ever had any orthodontic treatment? ❑Yes ❑No
14. Does patient require antibiotics for dental treatment? ❑Yes ❑No
15. Has patient ever received oral hygiene instructions regarding care of teeth/gums? ❑Yes ❑No
16. What are chief orthodontic (dental) concerns(s)?

_____

_____

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