dobbs | orthodontics

Date _____

Patient's Full Name ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. _____

Age _____ Birthdate _____ ☐ Male ☐ Female SS# _____

Home Address _____

Home Phone _____ Cell Phone _____ Work _____

Occupation _____ Email _____

How did you hear about our office? ☐ Dentist ☐ Family/Friend ☐ Internet ☐ Other _____

Have we treated another member of your family? Yes No If YES, Name _____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? _____

Address (if different) _____

Home Phone (if different) _____ Cell _____ Work _____

Social Security # _____ Employer _____

Who will be responsible for bringing the patient to orthodontic appointments? _____

DENTAL INSURANCE

Primary Policy Holder's Full Name _____ Birthdate _____

Social Security # _____ Relationship to Patient _____

Employer _____ Employer Address _____

Insurance Company Name _____ Address _____

Insurance Company Group # _____ ID # _____ Phone # _____

Secondary Policy Holder's Full Name _____ Birthdate _____

Social Security # _____ Relationship to Patient _____

Employer _____ Employer Address _____

Insurance Company Name _____ Address _____

Insurance Company Group # _____ ID # _____ Phone # _____

DENTAL INFORMATION

Patient's General Dentist _____ Last Appointment _____

What are the main concerns you would like orthodontics to address? _____

_____

Has you visited another orthodontist before? Yes No If YES, for what reason? _____

Now or in the past, have you had:

Yes No Supernumerary (extra) or congenitally missing teeth?
Yes No Popping, clicking, locking in jaw joints?
Yes No Soreness in jaw or face muscles?
Yes No Bleeding gums or gum disease?
Yes No Any sensitive or sore teeth?
Yes No Injury to teeth or jaws?
Yes No Frequent canker sores or cold sores?
Yes No Thumbsucking? (Stopped? Yes No)
Yes No Teeth causing irritation to lip, cheek or gums?
Yes No Tooth grinding or clenching?

MEDICAL HISTORY

Physician's Name _____ Phone Number _____
Do you regularly receive medication or medical treatment? Yes No
If YES, why? _____
Do you take any medication(s), including non-prescription medicine? Yes No
If YES, please list _____
Are you allergic to any medications and/or latex? Yes No
If YES, please list _____
Is there a history of any serious illness, accident, or operation? Yes No
If YES, please elaborate _____

Now or in the past, have you had:

Yes No Birth defects or hereditary problems?
Yes No Bone fractures, or major injuries?
Yes No Arthritis or joint problems?
Yes No Cancer, tumor, radiation treatment or chemotherapy?
Yes No Endocrine or thyroid problems?
Yes No Diabetes or low sugar?
Yes No Kidney problems?
Yes No Immune system problems?
Yes No Gonorrhea, syphilis, herpes, sexually transmitted diseases?
Yes No AIDS or HIV positive?
Yes No Hepatitis, jaundice or other liver problems?
Yes No Polio, mononucleosis, tuberculosis, pneumonia?
Yes No Seizures, fainting spells, neurologic problem?
Yes No Mental health disturbance or depression?
Yes No History of eating disorder?
Yes No Frequent headaches or migraines?
Yes No High or low blood pressure?
Yes No Excessive bleeding tendency or anemia?
Yes No Chest pain, shortness of breath, tire easily?
Yes No Heart defects, heart murmur, rheumatic heart disease?
Yes No Angina, arteriosclerosis, stroke, heart attack?
Yes No Vision, hearing, or speech problems?
Yes No Asthma, sinus problems, hayfever?
Yes No Tonsil or adenoid condition?
Yes No Does your child frequently breathe through his/her mouth?
Yes No Has your child ever taken intravenous or oral bisphosphonates for bone disorders/cancer?
Yes No Has your child ever been told to premedicate with antitibiotics prior to dental treatment?

AUTHORIZATION AND RELEASE

I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you. I will notify Dr. Dobbs of any future change in the patient's health or medication. I also hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by Dr. Dobbs to make a thorough diagnosis. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. Should I authorize direct payment of dental benefits otherwise payable to me to be payable to Dr. Dobbs directly, I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan. I understand, that where appropriate, a check of my credit history may be made. I also understand that my diagnostic records may be used for educational and promotional purposes.

Parent/Responsible Party's Signature | Relationship to Patient | Date

_____ _____ _____