PLYMOUTH ORTHODONTICS
BOOKWALTER | FEE | WRIGHT | SHIREY

We welcome you to our office. Please help us prepare for your visit by filling out the following information.

Patient's Name: _____

Prefers to be called: _____ Birth Date: _____ Age: _____

Sex: ☐ Male ☐ Female Gender: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Employer: _____ Occupation: _____

Cell phone number you prefer we use for appointment confirmation/communication: _____

Email you prefer we use for appointment confirmation/billing: _____

Other family members who have been seen in our office: _____

How did you hear about us? _____ Referred by: _____

Primary Dental Insurance

Insured's Name: _____

Relationship to patient: _____

Insured's DOB: _____

Insured's SSN or ID #: _____

Name of Insurance Company: _____

Orthodontic Insurance Benefits: _____

Secondary Dental Insurance

Insured's Name: _____

Relationship to patient: _____

Insured's DOB: _____

Insured's SSN or ID #: _____

Name of Insurance Company: _____

Orthodontic Insurance Benefits: _____

☐ Check here if no dental insurance

I understand that insurance claims will be submitted by Plymouth Orthodontics' office. I understand that I am responsible for all charges not paid by my insurance. I authorize release of any information relating to this claim to the insurance carrier.

Signature _____ Date _____

Medical History

Primary Care Physician: _____

Date of Last Visit: _____ Phone: _____

Please check any of the following medical conditions for which you have been treated:

- ☐ Adenoids removed
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ ADD/ADHD
- ☐ Autism Spectrum Disorder
- ☐ Benign Tumor
- ☐ Bone Disorder
- ☐ Cancer
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Endocrine problems
- ☐ Emotional problems
- ☐ Epilepsy/Seizures
- ☐ Gastrointestinal Disorders
- ☐ Headache/Migraine
- ☐ Heart condition
- ☐ Head/Facial Injury
- ☐ Hemophilia/Bleeding disorder
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Kidney/Liver Disease
- ☐ Oral Ulcers
- ☐ Previous Surgery
- ☐ Nervous Disorder
- ☐ Radiation/Chemotherapy
- ☐ Speech Problems
- ☐ Thyroid Problems
- ☐ Tonsils Removed
- ☐ Tuberculosis
- ☐ None of these

Other medical or behavioral concerns not listed above that you feel we should be aware of?_____

_____

Are you taking any medications? ☐ Yes ☐ No

*Please list medications*_____

Are you allergic to any medications? ☐ Yes ☐ No

*Please list medications*_____

Do you have any other allergies? ☐ Yes ☐ No

*Please specify*_____

Do you require antibiotic pre-medication for dental procedures? ☐ Yes ☐ No

*Please specify*_____

Are you pregnant? ☐ Yes ☐ No

Dental History

General Dentist: _____

Date of Last Visit: _____ City: _____

Reason for seeking orthodontic consultation? _____

_____

Please describe any previous orthodontic treatment, if any (duration, extent, upper/lower, length of treatment) _____

_____

Date _____ Dr. _____ City, State _____

Have you ever had any teeth extracted? ☐ Yes ☐ No

Have you ever been informed of having any missing or extra teeth? ☐ Yes ☐ No

Have you had any injuries to teeth, mouth or jaws? ☐ Yes ☐ No

*Please explain*_____

Do you have difficulty chewing or swallowing? ☐ Yes ☐ No

*Please explain*_____

Do you grind or clench your teeth? ☐ Yes ☐ No

Do you have pain in your jaw? ☐ Yes ☐ No

Does your jaw ever lock open? ☐ Yes ☐ No

Do you have any speech problems? ☐ Yes ☐ No

*Please explain*_____

Do you have any oral habits? *(lip sucking, tongue thrust, nail biting)* ☐ Yes ☐ No

*Please specify*_____

_____ _____

Responsible Party Signature Date