Battiste Orthodontics

Today's Date:

① About You

Name:

I prefer to be called: Please circle: Male Female

Email Address:

Birthdate: Age: SS#:

Home Address:

Home Phone:

Cell Phone: Service Provider:

For appointment reminders please circle text, email or both?

Employer:

Employer's Address:

Occupation:

Whom may we thank for referring you to our practice?

General Dentist:

Phone #: Date of last visit:

② Closest Relative

Spouse or closest relative name:

Relationship to Patient:

Address (if different from patient address):

Home Phone: Cell Phone:

③ Financial Responsibility

Person Responsible For Account: _____

Authorization: I certify that I am covered by _____ insurance company and I assign directly to Dr. Battiste all insurance benefits otherwise payable to me. I hereby authorize the dentist to release all information necessary to secure the payment of benefits and to use my signature for all insurance submissions, whether manual or electronic.

_____ _____

Signature Date

④ Dental Insurance

PRIMARY

Orthodontic Coverage: YES NO Dental Coverage: YES NO

Policy Holder's Full Name: SS#

Insurance Company Name:

Insurance Company Address:

Insurance Compancy Phone #:

Group #: ID #:

Insured's Name: Relation:

Insured's Birthdate: Insured's ID #:

Insured's Employer:

SECONDARY

Orthodontic Coverage: YES NO Dental Coverage: YES NO

Policy Holder's Full Name: SS#

Insurance Company Name:

Insurance Company Address:

Insurance Company Phone #:

Group #: ID #:

Insured's Name: Relation:

Insured's Birthdate: Insured's ID #:

Insured's Employer:

⑤ Emergency Contact Information

Name: Relation:

Home Phone: Work Phone:

Cell Phone:

⑥ Medical History

Do you have a personal physician? YES NO

Physician's Name:

Phone #: Date of last visit:

CONTINUED ON BACK…

⑥ Medical History continued

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain:

Are you taking any medications including over the counter?

Please list:

For Women only:

Are you pregnant? Yes No Week #:

Are you nursing? Yes No

Have you ever had any of the following diseases or medical problems?

Y	N	Abnormal Bleeding	Y	N	Hemophilia
Y	N	Anemia	Y	N	Hepatitis
Y	N	Artificial joints/valves	Y	N	High/Low Blood Pressure
Y	N	Asthma/Arthritis	Y	N	HIV+/AIDS
Y	N	Blood Transfusion	Y	N	Hospitalized in last 5 years
Y	N	Cancer/Chemotherapy	Y	N	Kidney Problems
Y	N	Congenital Heart Defect	Y	N	Mitral Valve Prolapse
Y	N	Diabetes	Y	N	Psychiatric Problems
Y	N	Difficulty Breathing	Y	N	Radiation Treatment
Y	N	Drug/Alcohol Abuse	Y	N	Rheumatic/Scarlet Fever
Y	N	Emphysema	Y	N	Severe/Frequent Headaches
Y	N	Epilepsy/Seizures	Y	N	Shingles
Y	N	Fever Blisters/Herpes	Y	N	Sickle Cell Disease/Traits
Y	N	Glaucoma	Y	N	Sinus Problems
Y	N	Heart Attack/Stroke	Y	N	Tuberculosis (TB)
Y	N	Heart Murmur	Y	N	Ulcers/Colitis
Y	N	Heart Surgery/Pacemaker	Y	N	Venereal Disease

Please list any other medical conditions that you have ever had:

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Dental Anesthetic	Y	N	Penicillin
Y	N	Metals/plastics	Y	N	Erythromycin	Y	N	Tetracycline
Y	N	Codeine	Y	N	Latex	Y	N	Other

Please list any drugs/materials that you are allergic to:

⑦ Dental History

What are your main concerns about your teeth?

Have you ever been evaluated for orthodontic treatment? Yes No

Have you ever had a problem with previous dental work? Yes No

Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMJD)? Yes No

Your Current Dental Health is: Good Fair Poor

Do you like your smile? Yes No

How often do you brush? (times per day)

Have you ever had an injury to your: Mouth Teeth Chin (please circle)

Do you have any speech problems? Yes No

Do you generally breathe through your mouth? Yes No

If yes, please circle: While Awake While Asleep

Have you ever taken Fosamax, or any other bisphosphonates? Yes No

Do you smoke or use tobacco in any form? Yes No

The information that I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature: Date:

Office Use Only

Doctor's Notes: