Welcome

freeman orthodontics

We would like to welcome you to our office. Our goal is to make every visit pleasant and educational.
We strive to teach good oral care that will enable you to have a beautiful smile that lasts a lifetime.

1 Tell Us About Yourself

Today's Date:_____

Name: _____
Birthdate: _____ Age:_____
Nickname:_____ Gender: _____
School:_____ Grade:_____
Hobbies/Sports:_____
Home#: _____
Cell#:_____
Home Address:
City:_____ ____ _____
Whom may we Thank for referring you? _____
General Dentist:
Last Exam Date:_____Any cavities?_____
Employer:_____
Marital Status: ❑ Single ❑ Married
❑ Widowed ❑ Divorced ❑ Separated

2 Spouse's Information

Spouse

Name:_____ DOB:_____
Address (If different):_____
_____
Wk#:( ) _____ Ext._____ Hm#:( )_____
Employer:_____

3 Nearest Relative Not Living With You.

Name:_____ Phone:_____
Address:_____
_____

4 Person Responsible For Account

❑ Self ❑ Other:

****Only fill out if different from Section 2.**

Name:_____ Relation:_____
Billing Address:_____
_____
City State Zip
Previous Address:_____
Hm#: ( )_____
Employer:_____
Wk#: ( )_____ Ext._____
SS#:_____

5 Primary Dental Insurance

Dental Coverage? ❑ Yes ❑ No Ortho? ❑Yes ❑ No
Insurance Co. Name:_____
Insurance Co. Address:_____
Insurance Co. Phone#: ( )_____
Group# (Plan, local, or Policy #):_____
Policy Owner's Name:_____
Relationship to Patient:_____
Policy Owner's DOB:_____
Policy Owner's SS#:_____

6 Secondary Dental Insurance

Dental Coverage? ❑ Yes ❑ No Ortho? ❑Yes ❑ No
Insurance Co. Name:_____
Insurance Co. Address:_____
Insurance Co. Phone#: ( )_____
Group# (Plan, local, or Policy #):_____
Policy Owner's Name:_____
Relationship to Patient:_____
Policy Owner's DOB:_____
Policy Owner's SS#:_____

7 Dental History

What would you like to accomplish with orthodontics?

_____
_____
_____

Have you ever been evaluated or had orthodontic treatment before? Y N
Have you had any injuries to the face/mouth/teeth/chin? Y N
Do you have any speech problems? _____
Have adenoids or tonsils been removed? Y N
Do you have any missing or extra permanent teeth? Y N
Have you ever had a serious/difficult problem associated with any previous dental work? Y N
Have you ever had any pain / tenderness in your jaw joint (TMI/TMD)? Y N
Do you brush your teeth daily? Y N
Floss your teeth daily? Y N

Please Circle to any of the following habits/allergies

Y N Clenching/Grinding Teeth
Y N Lip Sucking/Biting
Y N Mouth Breathing
Y N Snoring
Y N Nail Biting
Y N Tongue Thrust
Y N Allergic to Latex/Metals
Y N Allergic to Plastics

8 Medical History

Physician: _____

Phone#: ( )_____

Date of Last Visit:_____

Are you currently under the care of a physician? Y N

Do you smoke or use tobacco in any form? Y N

Have you ever been prescribed Fosamax, Y N
or any other bisphosphonate? If yes, when:_____

Have you ever taken Phen-Fen? Y N

Are you using a prescribed method of birth control? Y N

Are you pregnant? Y N # of weeks:_____

Are you Nursing? Y N

Please describe your current physical health:

❑ Good ❑ Fair ❑ Poor

Please list all drugs that you are currently taking:

_____

_____

_____

Please list all drugs/things that you are allergic to:

_____

_____

_____

Comments:

_____

_____

_____

9 Has you ever had any of the following medical conditions

Y N Abnormal Bleeding
Y N Anemia
Y N Blood Transfusions
Y N Difficult Breathing
Y N Drug/Alcohol Abuse
Y N Emphysema
Y N Epilepsy/Seizures/ Fainting
Y N Fever Blisters/Herpes
Y N Glaucoma
Y N Heart Attack/Stoke
Y N Heart Surgery/Pacemaker
Y N Any Hospital Stays
Y N Any Operations
Y N Artificial Bones / Joints / Valves
Y N Tuberculosis (TB)
Y N High/Low Blood Pressure
Y N Mitral Valve Prolapse
Y N Psychiatric Problems
Y N Sinus Problems
Y N Ulcers/Colitis
Y N Venereal Disease

Y N ADD/ADHD
Y N Lupus
Y N Asperger Syndrome
Y N Asthma
Y N Cancer
Y N Congenital Heart Defect
Y N Convulsions/Epilepsy
Y N Diabetes
Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis
Y N HIV +/ AIDS
Y N Kidney/Liver Problems
Y N Rheumatic/Scarlet Fever
Y N Radiation Treatment
Y N Severe/Frequent Headaches
Y N Shingles
Y N Sickle Cell Disease/ Traits

10

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

_____

Signature Date

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of th group insurance benefits directly to this office. I authorize

_____

Signature Date

This office reserves the right to verify the credit status of potential patients and/or prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting agencies.

_____

Signature Date

The Parent or Guardian who accompanies the child is responsible for payment at times of service unless prior arrangements have been made. Our office is HIPAA Compliant andcommitted to meeting or exceeding the standards of infection control mandated by OSHA, the CDA and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally retrieved the medical / dental information above with the parent / guardian & patient named herein.

Doctor's Comments Initials: _____ Date: _____

_____

_____

_____