clearsmile

WELCOME

To assist us in providing the most complete service, please provide the following information and health history.

Patient First/Last Name: _____ Preferred Name: _____

Date Of Birth: _____ Age:_____ SS#: _____

Address: _____ City: _____ State: _____ ZIP: _____

Employer: _____

E-mail: _____

Mobile #: _____ Home #: _____ Work #: _____

*Dentist: _____ What is Your Biggest Concern? _____

***Who can we thank for referring you to us?** _____

Describe Your Attitude Towards Treatment (***Circle One***):

I Want It Done Yesterday! **I'm Not Too Thrilled But I Know I Need It** **I Don't Even Want To Be Here ☹**

PARENT INFORMATION (*IF MINOR PATIENT*)

Responsible Party's First/Last Name: _____ Relationship to Patient: _____

Date of Birth: _____ SS#: _____ Employer: _____

Mobile #: _____ E-mail: _____

PRIMARY DENTAL INSURANCE

Orthodontic Coverage? O *Yes* OR O *No* If "*Yes*" please complete below:

Policy Holder's Name: _____ Policy Holder's Date Of Birth: _____

Policy Holder's SS# or ID#: _____

Policy Holder's Employer: _____ Group #: _____

Insurance Co. Name: _____ Insurance Co. Phone #: _____

Insurance Co. Address: _____

SECONDARY DENTAL INSURANCE

Orthodontic Coverage? O *Yes* OR O *No* If "*Yes*" please complete below:

Policy Holder's Name: _____ Policy Holder's Date Of Birth: _____

Policy Holder's SS# or ID#: _____

Policy Holder's Employer: _____ Group #: _____

Insurance Co. Name: _____ Insurance Co. Phone #: _____

Insurance Co. Address: _____

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MEDICAL HISTORY

O Yes	O No	Adenoids Removed
O Yes	O No	Anemia
O Yes	O No	Asthma
O Yes	O No	Birth Abnormalities
O Yes	O No	Bone Disorders
O Yes	O No	Diabetes
O Yes	O No	Earaches
O Yes	O No	Emotional Problems
O Yes	O No	Endocrine Problems
O Yes	O No	Epilepsy
O Yes	O No	Faintness/Dizziness
O Yes	O No	Heart Trouble
O Yes	O No	Hepatitis
O Yes	O No	Joint Swelling
O Yes	O No	Kidney or Liver Disease
O Yes	O No	Positive HIV Test
O **YES**	O **NO**	**PREGNANT (NO XRAYS!)**
O Yes	O No	Prolonged Bleeding
O Yes	O No	Rheumatic Fever
O Yes	O No	Sore Throats
O Yes	O No	Thyroid Problems
O Yes	O No	Tonsillitis
O Yes	O No	Tonsils Removed

List any other serious illnesses: _____

_____

Allergies: (check all that apply)

- O Latex
- O Metal
- O Drugs
- O Local Anesthetics
- O Other _____

Current Drugs/Medications: _____

_____

_____

Currently Under Physician's Care? O Yes O No

Physician_____

Reason_____

Comments _____

DENTAL HISTORY

Any previous orthodontic treatment?	O Yes	O No
Any previous orthodontic consultations?	O Yes	O No
Visits the dentist regularly? Recent Date: _____	O Yes	O No
Any missing permanent teeth?	O Yes	O No
Any pain or clicking on opening/closing mouth?	O Yes	O No
Any speech difficulties?	O Yes	O No
Any difficulty swallowing or chewing?	O Yes	O No
Is there any tongue-thrusting issues?	O Yes	O No
Mouth-Breathing when asleep?	O Yes	O No
Mouth-Breathing when awake?	O Yes	O No
Any extra permanent teeth?	O Yes	O No
More than average amount of decay/cavities?	O Yes	O No
Any injuries to the face, mouth, or teeth?	O Yes	O No
Any gum loss/recession or bone loss?	O Yes	O No

I understand that the information that I have given today is correct to the best of my knowledge. I also 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: _____

I understand that I am responsible for payment of services rendered. I understand I am responsible for paying any co-payment and deductible that my insurance will not cover. I also understand that insurance pays over my treatment time and does not pay in full up front. If I change or lose my insurance during my treatment I will be responsible for any charges remaining on the account.

Signature: _____

Date: _____