Braces by Dr. Ruth

PATIENT INFORMATION

Date_____

Patient's name _____
Last First Middle

Address _____
Street City Zip

2 NUMBERS REQUIRED

Home Phone _____ **Cell Phone** _____ **Work Phone**_____ Alt. _____

Birthdate_____ **Race: B W A H O Sex: F M Social Security #** _____

School_____ Grade _____ Email Address _____

Parent or guardian name _____

Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

Name _____
Last First Middle

Address (if different from above) _____
Street City Zip

Home Phone_____ **Work Phone**_____

Cell/other phone_____ **Email Address**_____

Social Security #_____ **Birthdate**_____ **Relationship to Patient** _____

Employer_____

Employer Address_____

DENTAL INSURANCE INFORMATION

Insured's Name_____ **Insured's Social Security #** _____

Insurance Company_____ **Group No.**_____ **Local No.**_____

Insurance Co. Address_____ **Phone No.** _____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_____ Insured's Social Security #_____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No._____

EMERGENCY INFORMATION

Name of nearest relative not living with you_____

Complete address _____
Street City Zip

Phone_____

DENTAL/MEDICAL HISTORY

What concerns you most about your teeth?_____ _____

Please circle Yes or No (If Yes, please fill in details)

Yes No Have you previously had an Ortho Consultation? _____
Yes No Have there been any injuries to face, mouth, or teeth?_____
Yes No Have you experienced an: Automobile accident Accidental Injury Major/Minor surgery
Blood transfusion Bleed/Clotting problem Hyperactivity
Yes No Is the patient in good health? _____
Yes No Is the patient allergic to any medication? _____
Yes No Is the patient taking any medication?_____
Yes No History of major illness?_____

Circle any of the medical conditions below that the patient has had or currently has:

Allergies	Diabetes	Frequent sinusitis	Sore throats
Asthma or Hayfever	Ear infections	High Blood Pressure	
Autoimmune disease	Epilepsy	Low blood pressure	
Blood disorder	Frequent colds	Smoker	

Circle any of the medical conditions below that the patient has had or currently has:

Mouth Breathing	Thumb Sucker (past or present)	Fingers (past) age___
Fingers (present)	Lip Sucking age ___	Lip Biting age ___
Pacifier	Tounge Thrust	Bruxism/clinching

How frequently do you have dental check-ups? Twice a year Once a year Only for emergencies None

Yes No Have you had a dental check-up in the last 6 months?_____
Yes No Is the patient presently in any dental pain? _____

How often do you brush? Once a day Twice a day Three times a day Four times a day Five times a day
Morning & bedtime Following meals After meals & snacks Rarely brushing Never
How often do you floss? Never Rarely Occasionally Once a day Twice a day Three times a day
More than 3 times a day Following meals

Yes No Do you use a supplemental rinse? Fluoride Antiplaque

Name of your General Dentist_____

Name of your Oral Surgeon (if one) _____

Name of your Periodontist (if one)_____

Please circle Yes or No (If Yes, please fill in details)

Yes No Has the patient ever lost or chipped any teeth? _____
Yes No Do gums bleed when brushing? _____
Yes No Any type of thumb or tongue habit? _____
Yes No Has the patient ever seen an Orthodontist?_____
Yes No Does the patient need extra help with instructions? _____
Yes No Do you know some appointments will be during school hours? _____
Yes No Have the tonsils or adenoids been removed?_____

Female Patients only:

Yes No Has menstruation started? _____
Yes No Is the patient pregnant?_____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Ruth Ross Edmonds to perform a complete orthodontic evaluation.

Signature: _____ **Date:** _____

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Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

I, _____, have received a copy of this office's Notice of Privacy Practices.

Print Name_____

Signature_____

Date_____

_____

For Office Use Only

_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)
