BRACES BY BLALOCK

Please fill out this form completely. The better we communicate the better we can care for you.

About You

Today's Date: _____

Name: _____
Last First MI Mr Mrs Ms Dr

E-mail Address:_____ SS:_____

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: ___/___/___ Age: _____S.S._____

Home Address: _____
Apt/Condo #

_____
City State Zip

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm#:(___)_____ Pager/Other#: _____

Wk#:(____)_____ Ext:____DL#:_____

Employer:_____

Employer's Address:_____

How long there?_____ Occupation: _____

Where & when are best times to reach you?_____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

General Dentist:_____

Last Visit Date: _____

Orthodontic Insurance

PRIMARY

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name:_____

Address:_____

Phone#:(____)_____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name:_____ Relation:_____

Policy Owner's ID#: _____ **DOB:** ____/____/____

Policy Owner's Employer: _____

SECONDARY

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name:_____

Address:_____

Phone#:(____)_____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name:_____ Relation:_____

Policy Owner's ID#: _____ **DOB:** ____/____/____

Policy Owner's Employer: _____

Spouse Information

His / Her Name:_____

Employer:_____

Wk#:(____)_____ Ext:____ SS#:_____

Birthdate: / /

In the event of an emergency, is there someone who lives near you that we should contact?

His/ Her Name: _____

Relations:_____

Wk#: (____)_____Hm#: (____)_____

Person Responsible for Account

Name:_____ Relation:_____

Employer:_____

Wk#:(____)_____ Ext:____ SS#:_____

Billing Address:_____

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name:_____

Phone #: (____)_____Date of last visit:_____

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 prescription/ over-the-counter drugs?

☐ Yes ☐ **No**

Please list each one:_____

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ **No**

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 Bones /Joints/ Valves	Y N	High / Low Blood Pressure
Y N	Asthma/Arthritis	Y N	HIV+/ AIDS
Y N	Blood Transfusion	Y N	Hospitalized
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/ Fainting	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
Y N	Heart Murmur	Y N	Ulcers/ Colitis
Y N	Heart Surgery/Pacemaker	Y N	Venereal disease

Please list any serious medical condition(s) that you have ever had: _____

_____

Are you allergic to any of the following?

Y N	Aspirin	Y N	Dental Anesthetics	Y N	Penicillin
Y N	Any Metals/Plastics	Y N	Erythromycin	Y N	Tetracycline
Y N	Codeine	Y N	Latex	Y N	Other

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

_____

Dental History

What are the main concerns that you would like orthodontics to accomplish? _____

_____

_____

Have you ever had or been evaluated for orthodontic treatment? ☐ **Yes** ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ **Yes** ☐ No

Do you now or have you ever experienced pain / discomfort in you jaw join (TMJ / TMD)?

☐ **Yes** ☐ No

Your current dental health is:

☐Good ☐ Fair ☐ Poor

Do you like your smile? ☐ **Yes** ☐ No

Gums ever bleed? ☐ **Yes** ☐ No

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

Mouth Teeth Chin

Do you have any speech problems?_____

Do you generally breather through our mouth?

☐ **Yes** ☐ No

If yes, please circle: While Awake? While Asleep?

Do you have any missing or extra permanent teeth?

☐ **Yes** ☐ No

Have you ever taken Fosamax, or any other bisphosphonate? ☐ **Yes** ☐ No

Have you ever taken Phen-Fen? ☐ **Yes** ☐ No

Do you smoke or use tobacco in any form?

☐ **Yes** ☐ 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

Thank you for filling out this form completely.

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

If this office accepts insurance, 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 the group insurance benefits (otherwise payable to me) directly to this office.

_____ _____

Signature of parent or guardian Date Signature of parent or guardian Date

Our office is HIPPA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials:_____ Date:_____

Doctor's Comments:

_____