

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 breathe 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:
