PLATINUM
ORTHODONTICS

PATIENT INFORMATION

Date_____

PATIENT INFORMATION

Patient's Name _____ Male____Female _____
First **Last** **Nickname**
Male____Female _____

Address _____
Street City Zip

Preferred Phone #_____Date of Birth_____Age_____

If patient is a minor, please provide name(s) of parent(s)/guardian(s) _____

How did you hear about our office? _____

School_____Grade_____

Children/Sibling: Name(s)_____Date(s) of Birth_____

RESPONSIBLE PARTY INFORMATION

Self/Parent/Guardian_____
First Last

Mailing Address _____
Street City Zip

How long at this address?_____Home phone_____ Cell phone _____

Can we send you Text messages: ☐ **Yes** ☐ **NO**

Email address_____

Relationship to Patient _____

Employer_____Occupation_____No. years employed _____

Person Financially responsible for this account: Self_____ Parent_____Guardian_____Other _____

DENTAL INSURANCE INFORMATION

(If Dental and/or Orthodontic Coverage, please provide card)

Insured's Name_____Date of Birth_____Social Security # _____

Employer _____

Insurance Company_____Group No._____ Phone No. _____

Do you have dual coverage? Yes_____ No_____ If yes, please provide that information and card as well

EMERGENCY INFORMATION

Emergency Contact (nearest you)_____Relationship to Patient _____

Address_____Phone _____

MEDICAL HISTORY

Physician_____ Date of Last Visit_____
Address_____ Phone _____

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

Yes No Are you in good health? _____
Yes No Do you have a history of a major illness? _____
Yes No Have you had any operations or been hospitalized? _____
Yes No Have you ever been involved in a serious accident? _____
Yes No Have you ever smoked or chewed tobacco? _____
Yes No Have seen a physician in the last 12 months? Why? _____
Yes No Are you taking any prescription and/or over-the-counter medication? _____
Yes No Are you allergic to any medication or substance (including latex or metals)? _____
Yes No Have any tonsils or adenoids been removed? _____

Female Patients only:

Yes No Are you pregnant? _____
Yes No Are you nursing?_____

Please circle any of the medical conditions below that you have had or currently have:

Abnormal bleeding/Hemophilia
Anemia
Arthritis
Asthma
Bone Disorders
Bronchitis
Cancer
Congenital Heart Defect
Diabetes
Developmental Disorder
Dizziness
Endocrine Disorder
Dizziness
Endocrine Disorder
Epilepsy/Convulsions/
Seizures
Glaucoma
Growth Disorder
Kidney Disease
Hay Fever/Allergies
Heart Attack/Stroke
Heart Murmur
Heart Problems
Hepatitis/Jaundice
Herpes/Cold Sores
High/Low Blood Pressure
HIV+ / Aids
Heart Problems
Hepatitis/Jaundice
Herpes/Cold Sores
High/Low Blood Pressure
HIV+ / Aids
Leukemia
Liver Disease
Lung/Respiratory Problems
Migraines/Severe Headaches
Nervous Disorders
Pneumonia
Prolonged Bleeding
Psychiatric Problems
Pneumonia
Prolonged Bleeding
Psychiatric Problems
Radiation/Chemotherapy
Rheumatic/Scarlet Fever
Sexually Transmitted Disease
Sinus Problems
Stomach Trouble/Ulcers
Thyroid Problems
Tuberculosis

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

DENTAL HISTORY

General Dentist_____ Phone number_____
Date of most recent dental exam/cleaning/x-rays _____
What are the main concerns that you would like Orthodontics to address? _____

Yes No Have you ever had or been evaluated for Orthodontic treatment? _____
Yes No Are you presently in any dental pain?_____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
Yes No Have you ever lost or chipped any teeth?_____
Yes No Have you ever been informed of any missing or extra teeth?_____
Yes No Have there been any injuries to face, mouth, or teeth?_____
Yes No Is any part of your mouth sensitive to temperature? Where? _____
Yes No Is any part of your mouth sensitive to pressure? Where?_____
Yes No Do your gums bleed when you brush? _____
Yes No Are you aware of your jaw joint clicking or popping (TMJ/TMD)?_____
Yes No Are you aware of clenching/grinding of your teeth? _____
Yes No Do you have any type of thumb or tongue habit? _____
Yes No Do you have any speech problems?_____
Yes No Are you a mouth breather? _____
Yes No Has anyone in your family received orthodontic treatment? _____
Yes No Are you aware that some appointments will be during school/work hours? _____

The undersigned hereby authorize the doctor to take x-rays, study models, photographs, or other diagnostic aids deemed appropriate by the doctor in order to make a thorough diagnosis of the patient's dental needs and to perform a complete orthodontic evaluation. . I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and the doctor. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payments and deductibles that my insurance does not cover. In the event of a default on agreed upon payment arrangements, I am responsible for reasonable collection costs. I have truthfully answered all of the above questions and agree and understand it is my responsibility to inform this office of any changes in my medical or dental history. I acknowledge that I have reviewed a copy of the Dental Materials Safety Fact Sheet and HIPPA Notice of Privacy Practices.

Signature (Parent/Responsible party if minor):_____ Date:_____
Doctor's signature (verbal review of medical information):_____ Date: _____

MEDICAL HISTORY UPDATES
Changes:
Parent/Guardian Signature_____ Date_____