GENERAL PATIENT INFORMATION

Date: _____

_____ ☐ Male ☐ Female

First Name Middle Name Last Name

_____

Address City State ZIP

_____ _____ _____

Email Age Birthdate

_____ _____ _____

Home Phone Work Phone Cell Phone

Responsible Party: _____ Relationship to Patient: _____

Resp. Party Social Security #: _____ Responsible Party DOB: _____

Address for Statements (if different from above): _____

City: _____ State: _____ ZIP: _____

Has Any Family Member Been a Patient Here? ☐ Yes ☐ No If Yes, Name: _____

Has Any Family Member Worn Braces Before? ☐ Yes ☐ No If Yes, Orthodontist Name: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

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

When Was The Last Time You Visited a Dentist Office? _____

Name of Dentist: _____ Phone#: _____

Who May We Thank For Referring You to Our Practice? _____

How Many Ways Have You Heard of Family-Braces?

- ☐ General Dentist
- ☐ Yellow Pages
- ☐ Family-Braces Patient
- ☐ TV / Radio
- ☐ Website / Internet
- ☐ Direct Mail
- ☐ Insurance Plan
- ☐ Your Company
- ☐ Family-Braces Employee
- ☐ Billboard / Office Sign
- ☐ Friend Name: _____

IF PATIENT IS OVER 18YRS

Employer: _____ Position: _____

Address: _____

Phone #: _____ Social Security #: _____

Spouse: _____ Employer: _____

Address: _____

Phone #: _____ Social Security #: _____

IF PATIENT IS UNDER 18YRS

Parent/Legal Guardian: _____

Employer: _____ Position: _____

Work Phone #: _____ Social Security #: _____

Marital Status? ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Please Complete if Parent/Legal Guardian is NOT the Financial Responsible Party (i.e. Grandparent or Aunt Paying Account)

Financial Resp. Party: _____ DOB: _____

Employer: _____ Position: _____

Work Phone #: _____ Social Security #: _____

PRIMARY ORTHODONTIC INSURANCE OR PRE-PAID PLAN

Policy Holder: _____ DOB: _____

Employer: _____ Insurance Company: _____

Insurance Phone #: _____ Address: _____

Policy/Group #: _____ Employee ID #: _____

I authorize the release of any information relating to this claim and understand that I am responsible for all costs of dental treatment and authorize payment directly to **FAMILY-BRACES** of the group insurance benefits otherwise payable to me

SIGNATURE: _____
(RESPONSIBLE PARTY)

DATE: _____

NEW PATIENT QUESTIONNAIRE

Name: _____ **Acct #:** _____ **Date:** _____

The following questions are designed to obtain your health history and to help us understand what you want to achieve from orthodontic treatment. We will confirm this information when we present your treatment options.

Chief Concerns Regarding My Teeth Are:

HEALTH INFORMATION

Does the patient have or has the patient ever had any of the following? *(please check all that apply)*

- ☐ High/Low Blood Pressure
- ☐ Rheumatic Fever
- ☐ Hepatitis
- ☐ Heart Trouble
- ☐ Diabetes
- ☐ Venereal Disease
- ☐ Fainting Spells/Seizures
- ☐ Arthritis
- ☐ Asthma/Hay Fever
- ☐ Epilepsy
- ☐ Radiation Therapy
- ☐ Stomach Ulcer
- ☐ Jaundice
- ☐ Aids/HIV
- ☐ Pregnancy (due date: _____)
- ☐ Anxiety

Y	N	
☐	☐	Does patient require antibiotics prior to treatment?
☐	☐	Is patient in good health?
☐	☐	Has there ever been trauma to patients face/teeth? **Explain:** _____
☐	☐	Is the patient presently under the care of a physician for an illness or disease?
☐	☐	Does the patient have a bleeding tendency or do wounds heal slowly?
☐	☐	Is the patient allergic to nickel, latex or any drugs or medications? **List:** _____
☐	☐	Is the patient taking any medications? **List:** _____

Due Date: _____

Signature:

CHECK ALL STATEMENTS BELOW THAT APPLY TO THE PATIENT

Teeth

- ☐ There are spaces between my teeth that I do not like.
- ☐ My teeth are crooked and overlapping.
- ☐ My teeth stick out too far.
- ☐ My mouth seems too small, not enough room for my teeth.
- ☐ My teeth are coming in the wrong places.
- ☐ Not aware of any problems.

Bite

- ☐ The bite is comfortable and I can eat what I want with no difficulties.
- ☐ I feel there is a problem with the bite or I have been told there is a problem.
- ☐ I have frequent or chronic pain in my jaws, face or head.
- ☐ My jaws click, pop, or lock when I open my mouth.
- ☐ I have or have had difficulty in opening and/or closing my jaws.
- ☐ I clench my teeth during the day or grind my teeth during the night.

Dentist

- ☐ I visit the dentist regularly, at least every _____ months.
- ☐ My last cleaning was in the month of _____.
- ☐ I have not seen the dentist for over a year. I am due for a cleaning.
- ☐ It has been _____ years since I had my teeth checked by the dentist.

Dental Problems

- ☐ I have no dental problems that I am aware of other than misaligned teeth.
- ☐ I am aware of other dental problems that need attention: _____

Orthodontist

- ☐ This is my first experience with an orthodontist.
- ☐ The patient has worn braces before. _____ **(year)**
- ☐ I have not seen the dentist for over a year. I am due for a cleaning.
- ☐ I have seen another orthodontist and I would like a second opinion. _____ **(Dr. name)**

What I Expect from Orthodontic Treatment

- ☐ I want all the teeth straightened and the bite corrected if possible.
- ☐ I want the upper and lower teeth straightened and aligned.
- ☐ I only want the upper teeth straightened and aligned.
- ☐ I only want to find out if any treatment is needed.

What Kind of Braces Do You Want?

- ☐ The least expensive (silver metal)
- ☐ The most cosmetic (clear ceramic)
- ☐ Removable and cosmetic (Invisalign)
- ☐ I need more information to make a decision.

Cost and Payment Plans

- ☐ I am interested in saving the most money by paying for the total treatment at the beginning.
- ☐ I am interested in making a down payment to reduce the total costs. $_____ **(amount)**
- ☐ I am looking for a payment plan with monthly payments of $_____ **(per month)**

Insurance

- ☐ I have insurance that may pay for a portion of the treatment costs. _____ **(provider)**
- ☐ I have no insurance that covers orthodontic treatment.

How Soon Would You Like to Get Started?

- ☐ I would like to get started as soon as possible if it is determined that treatment is indicated.
- ☐ I want to meet with the orthodontist to discuss the results of the diagnosis before making a decision.
- ☐ I want to discuss the findings with my spouse before making a decision to start treatment.
- ☐ I want to delay treatment as long as possible.

Patient Age: _____ years _____ months (if under 19) **Preferred Language:** _____

Best Time to Call Back: _____ **Phone #:** _____

Email: _____

Patient Consent For Use And Disclosure Of Protected Health Information

I have read and received the Notice of Privacy Practices and hereby give my consent for Family-Braces to use and disclose health information (PHI) about me/my child to carry out treatment, payment and healthcare operations (TPO).

Print Name:	**Signature:**	**Date:**

TREATMENT COORDINATOR NOTES

Set Up Next Appointment: _____

_____

Treatment Coordinator Signature: _____ **Date:** _____