WELCOME TO CAPPS ORTHODONTICS

ADULT PATIENT INFORMATION:

Name:_____ Prefer to be called:_____ Sex:_____

Home Address:_____ City:_____ State:_____ Zip:_____

Best number to be reached:_____ Age:____ Social Security #_____-_____-_____

Birthdate:_____ E-mail:_____

Dentist name:_____

Do you know a patient currently in our practice? If so, whom: _____

Who noticed your orthodontic problem? □ You □ Dentist □ Other _____

Describe your orthodontic problem in your own words:_____

What concerns you most about orthodontic treatment?

□ Appearance in appliances □cost □length of time □discomfort □results □other_____

Occupation: _____

Employer:_____ Address_____ Wk. Phone_____

How long with this employer? _____

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

Family And Account Information:

Spouses Name:_____ Employer:_____ Wk phone: _____

Person responsible for account: _____

If other than self or spouse:

Name: _____ Occupation:_____

Address: _____ City:_____ Zip:_____Phone: _____

In case of an emergency, please provide name, address and phone number of your nearest relative:

Name: _____Address:_____ Phone: _____

DENTAL INSURANCE INFORMATION:

If we do not accept assignment from your insurance provider, we will gladly assist you in submitting your claim forms regarding any charge for care in our office, so that you may be reimbursed directly by your insurance carrier.

Name of insured (Employee):_____Date of Birth: _____ Social Security: _____

Name of insurance company:_____ Group #: _____ ID #: _____

Name of insured (Employee):_____Date of Birth: _____ Social Security: _____

Name of insurance company:_____ Group #: _____ ID #: _____

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your orthodontic care. All information will be kept completely confidential.

MEDICAL HISTORY

Physician's Name: _____ Address: _____ Phone: _____
Have you ever experienced any health problems? □ No □ Yes Explain: _____
Any major change in your health recently? □ No □ Yes Explain: _____
Are you currently under a physician's care? □ No □ Yes Explain: _____
Are you currently taking any medications? □ No □ Yes List: _____
Are you allergic to any medications? □ No □ Yes List:_____
Have you received a blood transfusion? □ No □ Yes Reason: _____
Have your tonsils or adenoids been removed? □ No □ Yes When: _____

Please check if you have had any of the following conditions:

Heart Murmur/Surgery…□ No □ Yes	Hepatitis……..…..□ No □ Yes	Emotional Problems…. □ No □ Yes
AIDS……..……..……..□ No □ Yes	Diabetes.……..…..□ No □ Yes	Frequent Headaches…. □ No □ Yes
Rheumatic Fever…..……□ No □ Yes	Kidney Disease…□ No □ Yes	Nervous/Anxious…..…. □ No □ Yes
Endocrine disorders……□ No □ Yes	Liver Disease...…..□ No □ Yes	Cancer……..…. □ No □ Yes
Prolonged Bleeding……□ No □ Yes	Tuberculosis…….□ No □ Yes	Bone Disorders……. □ No □ Yes
Anemia……...……□ No □ Yes	Bronchitis…….□ No □ Yes	Growth Disorders……. □ No □ Yes
Blood Disease……□ No □ Yes	Asthma……..□ No □ Yes	Mouth Breather…...…. □ No □ Yes
Developmental Disorder.□ No □ Yes	Epilepsy...……□ No □ Yes	Herpes (Fever Blisters). □ No □ Yes
Hives/Rash….……□ No □ Yes	Fainting...…….□ No □ Yes	Tonsillitis……..…. □ No □ Yes

Is there any other condition or problem that you think we should know about? _____

DENTAL HISTORY

Dentist's Name: _____ Address: _____ Phone: _____
Dental Specialist's Name: _____ Address: _____ Phone: _____
Dental checkups: □2 times a year □1 time a year □Only if problem exists □Never Date of Last Visit:_____
Is there any unfinished care to be completed with your dentist? □ No □ Yes Explain: _____
Are you frightened about dental treatment? □ No □ Yes Explain: _____
Have you had an unpleasant experience in the dental office? □ No □ Yes Explain: _____
Have you had any facial or dental injuries? □ No □ Yes Explain: _____
Do you play any musical instruments? □ No □ Yes What instrument:_____
Have you consulted an orthodontist previously? □ No □ Yes With whom: _____
Have teeth (either primary or permanent) been removed? □ No □ Yes
Have you had any previous orthodontic treatment? □ No □ Yes With whom:_____
Are you satisfied with prior treatment? □ No □ Yes Explain: _____
Any changes in your bite or dental alignment recently? □ No □ Yes Explain: _____

Please check if there is a history of:
□ Clenching teeth □ Muscular Soreness around head & neck □Jaw joint soreness □Jaw joint popping
□ Grinding teeth □ Headaches (more than normal) □Jaw joint clicking □Ringing in the ears
□ Speech problems (if so what sounds _____) □Mouthbreathing Awake_____ Asleep_____
Is there any other information which may be helpful? _____

I certify that the above information is complete and accurate. I also understand that I am responsible for updating any changes or additions to this information in the future. I consent to a financial report.

_____ _____
Patient Signature **Date** **Reviewed by** **Date**