FREEMAN ORTHODONTICS

something to smile about

Welcome! Our specialty is creating smiles and to do this, we treat people, not just teeth. We care about your total health and appreciate your time in completing this health history.

PATIENT INFORMATION

Patient's Name____ Nickname____________________

Address, City, State, Zip:____

Home Phone (___)______________Cell Phone (___)______________ Birthdate___________ Age______

Responsible Party Email____

School____ Grade ____________

How did you hear about our office?____

Siblings/Children Yes/ No Name/Age________________________Name/Age ______________________

RESPONSIBLE PARTY INFORMATION

Name ____

Name ____

Mailing Address ____

Home Phone (___)_________________ Work Phone (___)_______________Cell (___)________________

Relationship to patient ________________________Can you receive calls at work? ___________________

ORTHODONTIC INSURANCE INFORMATION

Insured's Name ___________________________________ Insured's Social Sec. #____________________

Insured's Employer ____Insured's Birth date:_____________

Insurance Company ____Group #___________________

Insurance Co. Address____

Insurance Phone Number______________________________ Subscriber ID # ______________________

Do you have Dual Coverage? Yes or No

I hereby authorize payment directly to the above named orthodontist of the group insurance benefits otherwise payable to me.

_____________________________________ ____________ _____________________________

Signature (insured person) Date Insurance Co. Name

OFFICE USE ONLY ~~ INSURANCE VERIFICATION ~~OFFICE USE ONLY

Effective Date______________Wait period _______________ LM_____________@__________% Age___________

Deduct____________ Yearly or Onetime? Payment Schedule M / Q / S / A Billing Y / N Auto Bill

Group #____________________ Payor # ________________ Benefits Used/ Remaining ________________________

Initial Payment ____________________________ Other info ____

Claims Address ____

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DENTAL HISTORY

Dentist____ Date of last Visit _______________

Address, City, Zip____ Phone (___)_______________

What concerns you most about your teeth? ____

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

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 there been any injuries to face, mouth, or teeth? ___________________________

Yes No Is any part of your mouth sensitive to temperature or pressure? ____________________

Yes No Do your gums bleed when you brush?______________________________________

Yes No Do you have any type of thumb or tongue habit?_________________________________

Yes No Are you a mouth breather?____

Yes No Have you ever seen an orthodontist?_______________________________________

Yes No Has anyone in the family ever received orthodontic treatment?_______________________

How did they feel about the result? ____

What is your attitude toward receiving orthodontic treatment?____________________________

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? ______________

Yes No Are you aware of your jaw clicking or popping? ___________________________________

Yes No Have you ever been told that you grind your teeth?_________________________________

Yes No Do you have "tension" headaches? ____

Yes No Have you ever experienced chronic ringing in your ears? ___________________________

Yes No Are you aware that some appointments will be during school/work hours?__________________

MEDICAL HISTORY

Physician____ Date of last visit _____________

Address ____ Phone (___)_______________

Yes No Are you taking any medication? ____

Yes No Are you allergic to any medication? ____

Yes No Are you allergic to anything?____

Yes No Do you have a history of a major illness?_____________________________________

Yes No Have you had any major operations?____

Yes No Have you ever been involved in a serious accident? _____________________________

Circle any of the medical conditions below that you have had or currently have.

Abnormal Bleeding / Hemophilia	Diabetes	Dizziness	Epilepsy
Hepatitis / Liver Problems	Herpes	HIV+ / AIDS	Anemia
Gastrointestinal Disorders	Arthritis	Pneumonia	Tuberculosis
Radiation / Chemotherapy	Heart Murmur	Heart Problems	Bone Disorders
Congenital Heart Defect	Kidney Problems	Asthma	Hay fever
High Blood Pressure	Tumor or Cancer	Rheumatic Fever	Prolonged Bleeding

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

BENEFITS OF ORTHODONTICS

AESTETICS, HEALTH, FUNCTION

Orthodontics is a service that provides an improvement in the appearance of the teeth, in general the function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and swollen gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some changes after treatment.

I have read and understand the above paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in medical or dental history. I have had the opportunity to read and understand my Health Information (HIPPA) rights.

____ Patient/ Guardian Date___________________