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Welcome to Seacoast Orthodontics!

Please take a few minutes to complete these questionnaires so that we may better serve you. **(Please Print)**



Patient Information

Date _____

Patient Name _____ Birth date ____/____/____
First Last Nickname Month Day Year
Address _____ City _____ Zip code _____

Patient's Home Phone _____ E-Mail _____ Patient's Sex **M** **F**

Your Name _____ Relationship to Patient _____

Address _____ City _____ Zip code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____

Your Employer _____ Address _____

Your Marital Status (Circle) Single Married Separated Divorced Widowed Other _____

Spouse _____ Phone _____

(If applicable) First Last

Spouse Employer _____ Address _____



Financial Responsibility and Insurance Information

Person Responsible for Payment _____ Relationship to Patient _____

Address _____ City _____ Zip code _____
(Complete if different from above)

Employer _____ Address _____
(Complete if different from above)

Insurance Company _____ Insurance Phone _____

Insured's SS# _____ Insured's Birth date ____/____/____

Insurance Group # _____ Ortho Coverage (Circle) Y N Limits _____ % _____ Lifetime

Person with 2nd Insurance _____ Relationship to Patient _____

2nd Insurance Company _____ 2nd Insurance Phone _____

2nd Insured's SS# _____ 2nd Insured's Birth date ____/____/____

2nd Insurance Group # _____ Ortho Coverage (Circle) Y N Limits _____ % _____ Lifetime

Patient Dental Information

Dentist _____ Approximate Date of Last Visit _____

Tooth brushing Schedule per Day(Circle) 1X 2X 3X 4+ Flossing(Circle) No Daily Infrequently

Areas of Concern (Circle all that apply)

Crowding Protrusion Cross-bite Missing Teeth Extra Teeth
Jaw Soreness Gum Problems Speech Problems Bite is Off Slow Eruption

History of the following (Circle all that apply)

Trauma to Teeth/Face Mouth breathing Snoring Tongue Thrust
Finger/Thumb Sucking Grinding Clenching Headaches/Earaches
TMJ Clicking Jaw gets stuck TMJ Pain Previous Orthodontic Treatment
Family pattern of bite problems (Explain) _____



Patient Medical History

Physician _____ Approximate Date of Last Visit _____

Currently on Medication (Circle) YES NO If Yes, List _____

Any History of Allergies or Allergic Reaction to the following (Circle all that apply):

Penicillin or Other Antibiotics Sulfa Drugs Aspirin Tylenol(Acetaminophen)
Advil (Ibuprophen) Latex Nickel Local Anesthetics(Novocain)
Pollen/Seasonal Animals Foods (List) _____

Medical and Disease History (Circle all that apply):

Heart Murmur/Problems Anemia Arthritis Artificial Heart Valves/Joints
Asthma Back/Neck Problems Bleeding Problems Blood Disease
Cancer Chemotherapy Cold Sores AIDS/HIV Positive
Diabetes Epilepsy Emotional Problems Hepatitis (type) _____
Kidney Problems Liver Disease Migraines Under Care of Psychiatrist
Radiation Treatment Rheumatic Fever Skin Problems Stroke
Tuberculosis Vision/Hearing Disorder Other _____



Other Concerns

To get the best results, orthodontic treatment relies on good patient cooperation(i.e. good brushing, wearing elastics, not breaking braces loose from teeth, not eating hard or sticky foods) With this in mind, is there anything that would prevent this type of cooperation? YES NO

Please explain _____

Orthodontic treatment also uses diagnostic x-rays prior to and during treatment to monitor treatment Response and dental health, would you like us to (please circle):

Take appropriate x-rays as needed

Inform prior to taking and x-ray

Authorization

I have completed this form fully. The information provided is complete and correct. I agree to inform this office to and change at the next visit. I permit use of patient records for presentation at scientific meetings. I acknowledge that the financially responsible person named above is responsible for all changes and the balances remaining after insurance. I permit review of credit history for preparation of financial arrangements. I acknowledge receipt of "Notice of Privacy Practices".

Signature _____

Print Name _____