SEACOAST ORTHODONTICS

TIMOTHY FINELLI DDS AND JENNIFER SILLER DMD

Date_____

Doctors Timothy Finelli and Jennifer Siller welcome you to Seacoast Orthodontics

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

Patient Information

*Patient Name*_____

First *Last* *Nick name*

Date of Birth _____/_____/_____

Month Day Year

*Address*_____ *City*_____ *Zip code*_____

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

Parent(s)/Guardian(s) Information

Your Name _____ *Relationship to Patient* _____

*Address*_____ *City* _____ *Zip code*_____

Home Phone _____ *Work Phone* _____*Cell Phone* _____

E-mail _____

Your Employer _____ *Employer's Address*_____

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

Spouse's Information (if applicable)

Name _____ *Relationship to Patient* _____

Home Phone _____ *Work Phone* _____*Cell Phone* _____

E-mail _____

Employer _____ *Employer's Address*_____

How Did You Hear About Us?

Dentist _____ Insurance _____

Friend _____ Other _____

Financial Responsibility

*Name of Person Responsible for Payment*_____ *Relationship to Patient* _____

(only complete if different from above)

*Address*_____ *City* _____ *Zip code*_____

Home Phone _____ *Work Phone* _____*Cell Phone* _____

E-mail _____

Your Employer _____ *Employer's Address*_____

Insurance Information

Insurance Company _____ *Insurance Phone* _____

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

Month Day Year

Insurance ID # _____ *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* _____/_____/_____

Month Day Year

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 (Ibuprofen) *Latex* *Nickel* *Local Anesthetics (Novocain)*

Pollen/Seasonal *Animals* *None* *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

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 an x-ray

Authorization

I have completed this form fully. The information provided is complete and correct. I agree to inform Seacoast Orthodontics of any change(s) to the information provided above as soon as possible but no later than the next visit. I consent to the use of patient records for presentations at scientific meetings and **Seacoast Orthodontics' Facebook** page. I acknowledge that the financially responsible person named above is responsible for all changes and any balances remaining after insurance. I consent to the review of my credit history for the preparation of financial arrangements (if applicable). I acknowledge receipt of "Notice of Privacy Practices."

_____

Signature

_____

Print Name