ORTHODONTIC ALLIANCES, P.C.

PATIENT INFORMATION

Please fill out entire form and bring to your appointment completed.

A. PATIENT INFORMATION:

Name _____ Birthdate _____

Address _____ Marital Status _____

City State Zip _____

Phone (best number to reach you) _____ Email _____

We love referrals, how did you hear about Orthodontic Alliances?

B. LIST ALL RESPONSIBLE PARTIES (if patient is responsible go to next section):

1. Name _____ SS# _____ Birthdate _____

Address _____ Marital Status _____

City State Zip _____

Phone (best number to reach you) _____ Email _____

Employer name, address, phone _____

2. Name _____ SS# _____ Birthdate _____

Address _____ Marital Status _____

City State Zip _____

Phone (best number to reach you) _____ Email _____

Employer name, address, phone _____

C. DENTAL INSURANCE INFORMATION:

1. Name of Insurance Company _____ Group # _____

Address _____ Plan # _____

City State Zip _____

Authorization to bill insurance _____

2. Name of Insurance Company _____ Group # _____

Address _____ Plan # _____

City State Zip _____

Authorization to bill insurance _____

Signature _____

Acknowledgment of fees due and payable at time of service _____

D.

I understand that all X-ray fees are due and payable at the time of the visit. I understand that I am responsible for all lab fees incurred in the fabrication of a splint or orthodontic appliance in the event that I choose not to continue treatment. I understand that it is the policy of Orthodontic Alliances, PC that the parent who requests treatment for a minor child shall be responsible for all services rendered.

Signature _____ **Date** _____

PATIENT (PARENT IF PATIENT IS MINOR CHILD)

WELCOME TO ORTHODONTIC ALLIANCES

Dr. Randy Schmidt & Dr. Evan Schmidt are committed to EXCELLENCE in the specialized area of ORTHODONTIC and TMJ treatment. Our entire staff is here to serve you and help in the rendering of your care.

Please take a moment to completely fill out the patient information: medical, dental, orthodontic and TMJ histories. Do not skip any questions. A complete history allows us to know, diagnosis and properly care for you or your child. Thank you!

E. MEDICAL HISTORY

YES	NO	
_____	_____	Are you currently under any medical treatment? If yes, for what?_____ Who is your physician? _____
_____	_____	Are you currently taking medications? If yes, list medication. _____
_____	_____	Are you allergic to any medications? If yes, please list. _____
_____	_____	Women, are you pregnant?

Have you ever had any of the following? If yes, please check.

- ☐ Heart (Surgery, Disease, Attack)
- ☐ Chest Pain
- ☐ Congenital Heart Disease
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Artificial Heart Valve
- ☐ Heart Pacemaker
- ☐ Rheumatic Fever
- ☐ Arthritis/Rheumatism
- ☐ Cortisone Medicine
- ☐ Swollen Ankles
- ☐ Stroke
- ☐ Diet (Special/Restrictions)
- ☐ Artificial Joins (hip, knee, etc.)
- ☐ Kidney Trouble
- ☐ Ulcers
- ☐ Diabetes
- ☐ Thyroid Problems
- ☐ Glaucoma
- ☐ Contact Lenses
- ☐ Emphysema
- ☐ Chronic Cough
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Hay Fever
- ☐ Latex Sensitivity
- ☐ Allergies or Hives
- ☐ Sinus Trouble
- ☐ Radiation Therapy
- ☐ Chemotherapy
- ☐ Tumors
- ☐ Hepatitis A (infections) B (serum)
- ☐ Venereal Disease
- ☐ A.I.D.S.
- ☐ H.I.V. Positive
- ☐ Cold Sores / Fever Blisters
- ☐ Blood Transfusion
- ☐ Hemophilia
- ☐ Sickle Cell Disease
- ☐ Bruise Easily
- ☐ Liver Disease
- ☐ Yellow Jaundice
- ☐ Neurological Disorders
- ☐ Epilepsy or Seizures
- ☐ Fainting or Dizzy Spells
- ☐ Nervous / Anxious
- ☐ Psychiatric / Psychological Care

YES	NO	
_____	_____	Are there any other health problems not listed?

If yes, please describe_____

_____

_____

_____

F. DENTAL HISTORY

YES	NO	
_____	_____	Do you have a general dentist? If yes, print dentist's name _____ Date of last exam / cleaning _____
_____	_____	if no, would you like us to refer you to a dentist?
_____	_____	Do you have any dental pain or problems needing attention? If yes, please describe _____
_____	_____	Do your gums bleed or feel tender?
_____	_____	Have you had gum treatments?
_____	_____	Do you have teeth sensitive to hot / cold / sweets?
_____	_____	Have you had a root canal?
_____	_____	Does food get caught between your teeth?
_____	_____	Are any of your teeth loose?
_____	_____	Have your front teeth separated?
_____	_____	Do you have any missing permanent teeth?
_____	_____	Have you had any permanent teeth extracted?
_____	_____	Do you have a partial plate or complete denture?
_____	_____	If yes, does it fit properly? How old is it? _____
_____	_____	Do you have any high dental fillings, crown or bridges?

G. ORTHODONTIC HISTORY

YES	NO	
_____	_____	Have you ever had any orthodontic treatment? If yes, by whom? _____ When? _____
_____	_____	Are you unhappy with your facial appearance and profile?
_____	_____	Are you unhappy with the way your teeth look?
_____	_____	Do you feel your bite is changing?
_____	_____	Have you bumped, traumatized or fractured any teeth?
_____	_____	Do you have any of the following habits? (circle) Thumb, finger, lip or pacifier sucking; finger nail biting; biting other objects; Other _____
_____	_____	Do you snore?
_____	_____	Is it difficult for you to breathe through your nose?
_____	_____	Do you breathe with your mouth constantly open?
_____	_____	Do you have frequent sore throats?
_____	_____	Do you have frequent ear infections or tubes?

Please describe your problem or complaint _____

_____

_____

H. TMJ (JAW JOINT) HISTORY

YES	NO	
_____	_____	Do you now or have you ever had a TMJ problem? _____
_____	_____	If yes, have you ever been treated? _____ By whom? Dr. _____ When? Date _____
_____	_____	Have your teeth ever been ground down?
_____	_____	Do you have jaw joint or facial pain?
_____	_____	Does is hurt to chew or open wide?
_____	_____	Do you have difficulty opening or jaw locking?
_____	_____	Does your jaw joint pop or click? If yes, circle one. (Right) (Left) (Both)
_____	_____	Does your jaw joint make a grinding noise? If yes, circle one. (Right) (Left) (Both)
_____	_____	Do your ears ring, ache or feel stuffy? If yes, circle one. (Right) (Left) (Both)
_____	_____	Do you get dizzy frequently?
_____	_____	Do you clench, grind or grit your teeth?
_____	_____	Do your jaws ache or feel tired?
_____	_____	Do your teeth ache in the morning?
_____	_____	Do you have pain or difficulty swallowing?
_____	_____	Do you have a stiff or painful neck?
_____	_____	Has your jaw or chin ever been bumped or hit?
_____	_____	Have you ever had a head, neck or whiplash injury?
_____	_____	Do you have frequent headaches? If yes, circle the correct descriptions. Aching, Shooting, Stabbing, Burning or Electrical Intensity: (Severe) (Medium) (Light) Worse in: (Morning) (Afternoon) (Evening)

Please describe your problem. _____

_____

_____

_____

_____

I. I represent that all statements and answers contained herein, are to the best of my knowledge and belief, complete, true and correctly recorded and it is agreed that Orthodontic Alliances, and their staff et al. shall not be presumed to have knowledge or any information not so recorded.

Signature_____ **Date**_____

PATIENT (PARENT IF PATIENT IS MINOR CHILD)