ORTHODONTIC SPECIALISTS

KEVIN J ISON DMD MS

New Patient Information

Please Complete Both Sides

Patient Information

Date____

Patient's Name ____________________________________ Nickname ________________________ SS # _____________________

Address ____________________________________ City ___________________ State ________________ Zip _________________

Email ____ Birth Date _____/_____/_____ Age ________________ Gender ___________

Cell Phone ____________________________________ Home Phone ____

School ____ Grade ______________________________

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

Other family members seen by us ____

General Dentist ____ Address ____

Siblings: Name ____________________________________ Age ____ Name ______________________________________ Age _____

Who is with the child today?

Name ____ Relationship ____

Do you have legal custody of this child? Yes No

Responsible Party Information — Applies to Minors Only

Father's Name (or Self) ____

Address ______________________________ City _______________________ State _____________________ Zip _________________

Email Address ____

Cell Phone ____ Home Phone ___________________ Work Phone ____________________

SS # ____-____-____ Birth Date ____/____/____ DL #______________________ Relationship to Patient ________________________

Employer ___________________________________

Mother's Name (or Spouse) ____

Address ______________________________ City _______________________ State _____________________ Zip _________________

Email Address ____

Cell Phone____ Home Phone ____________________ Work Phone ____________________

SS # ____-____-____ Birth Date ____/____/____ DL #______________________ Relationship to Patient ________________________

Employer __________________________ Person financially responsible for this account Father/Self ❑ Mother ❑

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑

Orthodontic Insurance Information

Primary Insured Name____ Birth Date ____/____/____ SS # ____-____-____

Insurance Company____ Group No. ____________ Employer _____________

Insurance Co. Address ________________ City ________________ State _________________ Zip __________ Phone ________________

Do you have dual coverage? ❑ Yes ❑ No

Secondary Insured's Name ____ Birth Date ____/____/____ SS # ____-____-____

Insurance Company____ Group No. ____________ Employer _____________

Insurance Co. Address ________________ City ________________ State _________________ Zip __________ Phone ________________

Emergency Information

Name of nearest relative not living with you ______________________________ Complete Address________________________________

Phone ____

DENTAL HISTORY

Why is the patient being seen by the orthodontist today?_____________

Has the patient ever had any pain or tenderness in the jaw joint (TMJ/TMD) Y N

Has the patient ever had a serious/difficult problem associated with dental work? Y N

Is the patient's water fluoridated? Y N

Is the patient taking fluoridated supplements? Y N

Does the patient brush teeth daily? Y N

Types of bristles? Hard Medium Soft

Floss their teeth daily? Y N

Does the patient like their smile? Y N

Does the patient's gum ever bleed? Y N

MEDICAL HISTORY

Does the patient have a personal physician? Y N

Name:____

Phone:________________ Last visit:_____________

Is the patient currently under the care of a doctor?

Y N Explain:__________________________________

Please describe the patient's health:

Good Fair Poor

Please list all drugs the patient is currently taking: ____________________

____

Has the patient ever had any of the following diseases or medical problems?

Y N Prosthesis	Y N History of Scarlet Fever
Y N Heart attack	Y N Congenital Heart Def.
Y N Cancer	Y N Convulsions/Epilepsy
Y N Diabetes	Y N Abnormal Bleeding
Y N Rheum. Fev.	Y N Artificial Valves
Y N HIV/AIDS	Y N Heart Surgery/Pacmkr.
Y N Hemophilia	Y N Any Stays in hospital
Y N Asthma	Y N Kidney/Liver problems
Y N Hepatitis	Y N Mitral Valve Prolapse
Y N Tuberculosis	Y N Artificial Bones/Joints
Y N Shingles	Y N Sev./Freq. Headaches
Y N Fever Blister	Y N Hi/Lo Blood Pressure
Y N Venereal Disease	Y N Drug/Alcohol Abuse
Y N Ulcers/Colitis	Y N Blood Transfusion
Y N Heart Murm.	Y N Anemia/Radiation Tmt.
Y N Emphysema	Y N Glaucoma
Y N Sinus Problems	Y N Difficulty Breathing
Y N Hearing Impairment	Y N Handicaps/Disabilities
Y N Other:	

Is the patient allergic to any of the following?

Y N Aspirin	Y N Erythromycin
Y N Codeine	Y N Dental Anesthetics
Y N Latex	Y N Tetracycline
Y N Penicillin	Y N Other:

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

Does the patient have any of the following habits?

Y N Thumb Sucking/Finger Sucking

Y N Lip Sucking/Biting

Y N Nail Biting

Y N Nursing Bottle Habits

FOR WOMEN ONLY:

Are you taking birth control pills? Y N

Are you pregnant? Y N Week #:______________________

Are you nursing? Y N

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in the patient's medical status. I also authorize the dental staff to perform the necessary dental services the patient may need during treatment. I am aware that where appropriate, credit bureau reports may be obtained.

____

Signature Date

Payment is due in full at time of treatment unless prior arrangements have been approved.

OFFICE USE ONLY --- OFFICE USE ONLY --- OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient/guardian

Initials:______________________ Date: ________________

Doctor's comments:___________________________________

____

Medical History Update:

1. Date:__________________ Signature: _________________

Comments: _______________________________________

2. Date:__________________ Signature: _________________

Comments: _______________________________________