Welcome to Springfield Orthodontics & Associates!

Please take a few moments to fill out this necessary information that will enable us to better serve you.

***PATIENT’S INFORMATION***

Name \_\_\_\_\_ \_\_\_\_\_Age Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex M F

Address \_\_\_\_\_\_City \_\_\_\_\_Zip

Patient lives with (please circle) Mom/Dad/Guardian Home # \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_Cell #

Work number if applicable\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s Preferred Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of school attending Grade

Interests/Hobbies\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any emotional/behavioral concerns that may have an impact on our treatment? If yes, please explain:

***RESPONSIBLE PARTY INFORMATION***

Mother/Guardian Name \_ Occupation

Address (if different from above)

Father/Guardian Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Address (if different from above) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family E-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Family members currently being treated

Whom can we thank for referring you to our office?

***DENTAL INSURANCE INFORMATION***

Insurance Subscriber Phone

Subscriber’s Date of Birth Subscriber’s Social Security Number

Employer

Insurance Provider ID#

2nd Insurance Subscriber Phone

Subscriber’s Date of Birth Subscriber’s Social Security Number

Employer

2nd Insurance Provider ID#

***ORAL HEALTH HISTORY***

Dentist Phone Last visit

Address City State Zip

Why are you seeking treatment?

***MEDICAL HISTORY***

Physician name Phone

Address City State ZIP

Are you currently under a physician’s care? If yes, please explain

*Date Updated (For office use )*

Is there any immediate family history of: (please circle)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| HEART DISEASE | Y/N | KIDNEY DISEASE | Y/N | NASAL BLOCKAGE | Y/N | EMOTIONALPROBLEMS | Y/N |
| RHEUMATIC FEVER | Y/N | DIABETES | Y/N | DRUG/ALCOHOL USE | Y/N | PSYCHIATRIC THERAPY | Y/N |
| HEART MURMUR | Y/N | SEIZURES | Y/N | HEPATITIS/JAUNDICE | Y/N | DIGESTIVE DISORDER | Y/N |
| HIGH BLOOD PRESSURE | Y/N | ASTHMA | Y/N | TUBERCULOSIS | Y/N | HOSPITALIZATION/  SURGERY | Y/N |
| AIDS/HIV+ | Y/N | ARTHRITIS | Y/N | THYROID DISEASE | Y/N | BLOOD/ DISORDER | Y/N |
| FREQUENT COLDS | Y/N | BIRTH DEFECT | Y/N | MAJOR ILLNESS | Y/N | OTHER | Y/N |

If you answered YES to any of the medical history, please explain

Are you taking medications? Y/N If so, what?

Do you have any food or other allergies? Y/N If so, what?

IS THERE ANY HISTORY OF: (PLEASE CIRCLE)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Y/N | CLICKING OF JAW (TMJ) | Y/N | SUCK THUMB/FINGERS | Y/N | SPEECH PROBLEM | Y/N | DIFFICULTY CHEWING |
| Y/N | PAIN IN JOINTS (EARS) | Y/N | TONGUE THRUST HABIT | Y/N | DRY MOUTH | Y/N | EXTRACTION OF TEETH |
| Y/N | INJURIES TO TEETH | Y/N | MOUTH BREATHING | Y/N | FEVER BLISTERS/ ULCERS | Y/N | MISSING TEETH |
| Y/N | INJURIES TO FACE | Y/N | PRIOR ORTHODONTICS | Y/N | GRINDING TEETH | Y/N | OTHER |

If yes to any of the above, please explain

To the best of my knowledge, all the preceding answers are true and correct. I hereby give permission to Dr. Ian Thomas and his Associates and Clinical Team to take necessary x-rays, photos, digital scans or study models to enable complete diagnosis as well as use of these records for educational purposes.

Person Responsible for Account

Signature of Responsible Party­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship \_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_