THIS FORM IS FOR PATIENTS AGE 18 OR OLDER

STAMFORD ORTHODONTICS

Welcome to Stamford Orthodontics, where we take pride in creating healthy beautiful smiles that will last a lifetime. We hope your visit is a pleasant and educational experience.

Patient Information

Today's Date: _____/_____/_____

Patient's Name:_____
Last First MI

Title: Mr. Mrs. Miss Dr. Other_____ ☐ Male ☐ Female

I prefer to be called_____

Birthdate: ____/____/_____ Age____ S.S. #_____

Home Address:_____
Apt.#

_____
City State Zip Code

Email Address: _____

Circle one: Single Married Separated Divorced Widowed

Home Phone#_____Cell#_____

Work #_____Occupation_____

Employer_____

Work Address:_____

_____
City State Zip Code

Who may we thank for referring you?_____

Who is financially responsible for account?_____

Other family members seen by us_____

Dentist:_____Phone #_____

Spouse or closest relative_____

Title: Mr. Mrs. Miss Dr. Other____ Relation_____
Address
(If different from patient)_____

_____

Employer_____

Home Phone#_____Cell #_____

Relative/Friend not living with you_____

Relation_____

Home Phone#_____Cell#_____

Orthodontic Insurance

Primary Policy

Policy holder's full name:_____

Birthdate ___/____/_____ S.S.# _____

Relationship to patient _____

Employer:_____Phone#_____

Insurance Company Name_____

Address:_____

_____
City State Zip Code

Insurance Co. Phone #_____

Group # _____ ID #_____

Secondary Policy

Policy holder's full name:_____

Birthdate: ___/____/_____

S.S.#_____

Relation to patient_____

Employer_____Phone#_____

Insurance Company Name_____

Address:_____

_____
City State Zip Code

Insurance Co. Phone # _____

Group # _____ ID #_____

Authorization

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature _____**Date**_____

Dental and Medical History

The following information is for our office records only, and is confidential.

Physician:_____ Doctor's Phone #_____
List medication, nutritional supplements, herbal medications or non-prescription medicines that you are taking:

_____

How would you describe your physical health? Circle: Good Fair Poor

List all drugs/food, etc. that you are allergic to:_____

Are you allergic to: Latex Y N Nickel/Metals N Y Plastic Y N

Have you had a serious/difficult problem associated with any previous dental work? Y N_____

What are your main concerns about your teeth? _____

Y N Have you had previous orthodontic treatment? If yes, describe:_____

Y N Have there been any injuries to the face, mouth, teeth or chin? Y N Have you had any pain/tenderness in the jaw joint?

Have you experienced the following medical conditions?

Y N Abnormal Bleeding
Y N AIDS/HIV
Y N Alcohol/Drug Abuse
Y N Bone Fractures, or Major Injuries
Y N Arthritis or Joint Problems
Y N Cancer or Tumor
Y N Radiation Treatment/Chemotherapy
Y N Endocrine or Thyroid problems
Y N Diabetes or Low Sugar
Y N High or Low Blood Pressure
Y N Herpes/Fever Blisters
Y N Heart Attack/Stroke
Y N Glaucoma
Y N Hearing Impairment
Y N Mitral Valve Prolapse
Y N Colitis
Y N Rheumatic/Scarlet Fever
Y N Immune System Problems
Y N Hepatitus/Jaundice/Other Liver Problems
Y N Sickle Cell Disease/Traits
Y N Prosthetics
Y N Handicaps/Disabilities
Y N Emphysema
Y N Lupus
Y N Epilepsy
Y N Hay Fever
Y N Heart Defects/Murmur
Y N Hemophilia
Y N Frequent Headaches
Y N Sinus Problems
Y N Tuberculosis
Y N Kidney problems
Y N Excessive Bruising/Anemia
Y N Asthma/Difficulty Breathing
Y N Seizures/Fainting Spells
Y N Psychiatric Problems

Please discuss any serious medical problems you have had:_____

_____

Do you experience any of the following: (Circle) Ginding Teeth Mouth Breathing Nail Biting

I understand that the information I have given is correct to the best of my knowledge, and that it will be held in the strictest confidence. It is my responsibility to inform this office of any changes in my medical status.

Signature _____ **Date**_____

For Office Use Only

I have verbally reviewed the medical/dental information above with the patient named herein.

Signature of Dentist_____**Date**_____

Medical History Update

Change in Health Status: _____

Dentist Signature_____Date_____ Patient Signature_____Date_____

Change in Health Status: _____

Dentist Signature_____Date_____Patient Signature_____Date_____