

BRIGHTON ORTHODONTICS

About You

Today's Date: ___/___/___ Male Female

Name: _____
LAST FIRST MI

Preferred Name: _____ Marital Status: S M D W

Birthdate: ___/___/___ Age: ___ SSN: _____

Address: _____

CITY STATE ZIP

Email: _____

Employer: _____

How long there? _____ Occupation: _____

Home Phone: _____ Cell: _____

Work Phone: _____

Whom may we thank for referring you:

Preferred appointment reminder method:

Email _____

Text # _____

Insurance Information

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: _____

Insured's ID #: _____

Group #: _____

Insured's Name: _____

Insured's Birthdate: ___/___/___

Secondary Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: _____

Insured's ID #: _____

Group #: _____

Insured's Name: _____

Insured's Birthdate: ___/___/___

Spouse Information

His/Her Name: _____

Employer: _____

Work Phone: _____ Cell: _____

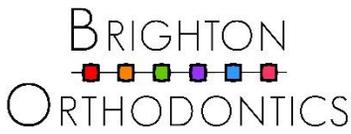
Birthdate: ___/___/___

In the event of an emergency, whom would you like us to contact?

His/Her Name: _____

Relation: _____

Home Phone: _____ Cell: _____



Dental and Medical History

General Dentist: _____ Phone: _____

Address: _____

Last cleaning: ___/___/___ Have you ever been evaluated for or had orthodontic treatment before: Y / N

What are the main concerns that you would like orthodontics to accomplish: _____

Do you or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Y / N

Grind teeth : Y / N

Mouth Breather: Y / N

Missing Teeth: Y / N

Have Tonsils Adenoids been removed?

Have you experienced any unfavorable reaction from any previous dental or medical care? Y / N

Do you require antibiotics before dental procedures? Y / N

If yes, please specify and give reason for this need: _____

Family Physician: _____ Phone: _____

Address: _____

Are you currently under a physician's care? Y / N If yes, explain: _____

Are you taking any medicine at this time? Y / N Please specify: _____

Are you allergic to any medications? Y / N Please specify: _____

Do you have any known allergies (nuts, latex, etc.)? Y / N Please specify: _____

Have you been hospitalized or had any surgeries?? Y / N Please specify: _____

Do you have any history of these?:

Yes / No Seasonal Allergies

Yes / No Lung Disorder

Yes / No Heart Disorder/Murmur

Yes / No Speech Difficulties

Yes / No Anemia

Yes / No Breathing difficulties

Yes / No Hypertension

Yes / No Emotional Disorders

Yes / No Prolonged bleeding/Clotting Disorder

Yes / No Asthma

Yes / No Congenital Heart Disease

Yes / No Hearing difficulties

Yes / No Bone Problem or Disorder

Yes / No Bronchitis

Yes / No Rheumatic fever

Yes / No Arthritis/Joint Swelling

Yes / No Tuberculosis

Yes / No Endocrine/Hormone disorders

Yes / No Artificial Joint

Yes / No Neurologic disorder

Yes / No Diabetes

Yes / No AIDS or HIV

Yes / No Cerebral palsy

Yes / No Hepatitis or Liver Disorder

Yes / No ADD/ADHD

Yes / No Convulsions/ Seizures

Yes / No Kidney or bladder Disorder

If you are experiencing or have a history of any disease, condition or problem not addressed, please explain:

Signature: _____ Date: _____