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Member American Association of Orthodontists®
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ABO American Board of Orthodontics

Welcome to our practice. The benefits of a happy, healthy, beautiful smile are immeasurable! Please fill out this form completely. The better we communicate, the better we can care for you.

Patient Information

Today's Date: _____
Name (First, M.I., Last): _____ Preferred Name:_____ Male / Female
Birthdate: _____ Age: _____
Marital Status: Single ___ Married ___ Separated ___ Divorced ___ Widowed ___
Home address: _____ How long at this address? _____
Home telephone: _____ Cell phone: _____ Email: _____
Employer: _____
Occupation: _____ How long at present job? _____
Employer Address: _____
Work telephone w/ ext: _____
What concerns you about your smile / bite? _____
Have you ever been evaluated or had orthodontic treatment before? _____
Have we treated other family members? _____ If so, whom? _____
Whom may we thank you for referring you? _____

Your Medical / Dental History

Do you have a personal physician? Y / N Name of physician: _____
Phone number of physician: _____ Date of last visit: _____
Are you currently under the care of a physician? Please explain. _____
Have you been hospitalized for any reason? Y / N If yes, please explain:_____
Please list any medications you are taking (including non-prescription): _____
Please list any allergies to medicines/foods/substances (for example: latex/metals/plastics): _____
Have you ever taken IV or oral bisphosphonates for bone disorders or cancer? Y / N
Do you use tobacco? Y / N
For female patients only: Are you pregnant or possibly could be? Y / N

Please check all that may apply—presently or in the past.

Arthritis or other bone disorder	Y / N	Heart trouble (artificial valve, congenital heart defect, heart attack/stroke, mitral valve prolapse, murmur, surgery, pacemaker)	Y / N
Artificial joints / implants	Y / N		
Asthma	Y / N		
Birth defects	Y / N	Hepatitis	Y / N
Cancer	Y / N	High / Low Blood Pressure	Y / N
Diabetes	Y/ N	HIV / AIDS	Y / N
Drug / Alcohol abuse	Y / N	Rheumatic / Scarlet Fever	Y / N
Epilepsy / fainting / seizures	Y / N	Tonsils / Adenoids removed	Y / N
Excessive bleeding / Anemia / Other Blood Disorder	Y / N	Hearing impairment	Y / N
Headaches	Y / N	Sinus problems	Y / N
		Thyroid problems	Y / N
		Tuberculosis	Y / N

Are there any other medical or physical conditions? _____

Do you pre-medicate with antibiotics for dental procedures? Y / N

Your Dentist: _____ Date of last cleaning: _____
Was any dental treatment recommended that needs to be completed? _____
Have there been any injuries to the face/mouth/teeth/chin? Y / N Please explain: _____
Are you aware of any missing/extra permanent teeth? Y / N
Do you have any oral habits (thumb/finger/tongue/lip sucking, nail biting, grinding/clenching, tongue thrust)? Y / N
If yes, please explain: _____
Have you experienced any jaw joint discomfort? Y / N Popping / clicking? Y / N
Do you brush your teeth adequately? Y / N
Do you floss daily? Y / N

Responsible Party (if different from above)

Name: _____
Birthdate: _____
Relation to patient: _____
Address: _____
Email address: _____
Cell phone: _____
Work phone w/ ext: _____
Employer / Occupation: _____
How long at current job? _____

Primary Insurance Information

Insurance Company: _____ Insurance Phone Number: _____
Employer / Group Name: _____ Group number: _____
Subscriber / Employee: _____ Subscriber ID: _____
Social Security Number: _____ Date of Birth: _____ Relationship to patient: _____

Secondary Insurance Information

Insurance Company: _____ Insurance Phone Number: _____
Employer / Group Name: _____ Group number: _____
Subscriber / Employee: _____ Subscriber ID: _____
Social Security Number: _____ Date of Birth: _____ Relationship to patient: _____

Emergency Contact Information (Other than responsible party):

Name: _____ Relationship to patient: _____
Cell phone: _____ Home phone: _____ Work phone: _____

I understand that the information that I have given is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my medical status.

I understand the office of Dr. Deborah Sema may use my health information for treatment, billing, and healthcare operations. I have been given a copy of the Notice of Privacy Practices to read and know that I may obtain my own copy if desired.

Our office reserves the right to verify the credit status of potential patients.

_____ _____
Signature of patient **Date**