# WELCOME

## To Schouten Orthodontics

### 1 Tell Us About You

Today's Date: ____/____/____
Email Address: _____
Name: _____
I prefer to be called: _____ ☐Male ☐Female
Birthdate: ____/____/____ Age: _____ SS#: _____
Home Address: _____
_____
☐Single ☐Married ☐Divorced ☐Widowed ☐Separated
Hm #: (____)_____ Pager/Other #: _____
Wk#: (____)_____ Ext: ____ DL#: _____
Employer: _____
Employer's Address: _____
How long there? _____ Occupation: _____
Where & when are best times to reach you? _____
Whom may we Thank for referring you? _____
Other family members seen by us: _____
General Dentist: _____
Last Visit date: _____

### 2 Spouse's Information

His/Her Name: _____
Employer: _____
Work #: (____)_____ Ext: ____ SS #: _____
Birthdate: ____/____/____

Person Responsible for Account: _____
Wk#: (____)_____ Ext: ___ Hm#: (____)_____
Billing Address: _____
Relation: _____ SS#: _____
Employer: _____ DL#: _____

### 3 Insurance

**Primary Insurance**

Ortho Coverage ☐Yes ☐No Dental Coverage ☐Yes ☐No
Insurance Co. Name: _____
Insurance Co. Address: _____
Insurance Co Phone: (____)_____
Group # (Plan, Local, or Policy #): _____
Insured's Name: _____ Relation: _____
Insured's Birthdate: ____/____/____
Insured's ID# _____

**Secondary Insurance**

Ortho Coverage ☐Yes ☐No Dental Coverage ☐Yes ☐No
Insurance Co. Name: _____
Insurance Co. Address: _____
Insurance Co Phone: (____)_____
Group # (Plan, Local, or Policy #): _____
Insured's Name: _____ Relation: _____
Insured's Birthdate: ____/____/____
Insured's ID# _____

**In the event of an emergency, is there someone who lives near you that we should contact?**

Name: _____ Relation: _____
Wk #: (____)_____ Hm#: (____)_____

### 4 Medical History

Do you have a personal Physician? ☐Yes ☐No
Physician's Name: _____
Phone #: (____)_____ Date of last visit: _____

## 5 Medical History *continued*

**Your current physical health is:** ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Are you taking any prescription/over-the-counter drugs? ☐ Yes ☐ No

Please list each one: _____

**For Women:**

Are you pregnant? ☐ Yes ☐ No Week #_____

**Have you ever had any of the following diseases or medical problems?**

| | | | |
|---|---|---|---|
| Y N | Abnormal Bleeding | Y N | Hemophilia |
| Y N | Anemia | Y N | Hepatitis |
| Y N | Artificial Bones/Joints/Valves | Y N | High/Low Blood Pressure |
| Y N | Asthma/Arthritis | Y N | HIV+/AIDS |
| Y N | Blood Transfusion | Y N | Hospitalized for Any Reason |
| Y N | Cancer/Chemotherapy | Y N | Kidney Problems |
| Y N | Congenital Heart Defect | Y N | Mitral Valve Prolapse |
| Y N | Diabetes | Y N | Psychiatric Problems |
| Y N | Difficulty Breathing | Y N | Radiation Treatment |
| Y N | Drug/Alcohol Abuse | Y N | Rheumatic/Scarlet Fever |
| Y N | Emphysema | Y N | Severe/Frequent Headaches |
| Y N | Epilepsy/Seizures/Fainting | Y N | Shingles |
| Y N | Fever Blisters/Herpes | Y N | Sickle Cell Disease/Traits |
| Y N | Glaucoma | Y N | Sinus Problems |
| Y N | Heart Attack/Stroke | Y N | Tuberculosis (TB) |
| Y N | Heart Murmur | Y N | Ulcers/Colitis |
| Y N | Heart Surgery/Pacemaker | Y N | Venereal Disease |

Please List any serious medical condition(s) that you have ever had:

_____

**Are you allergic to any of the following?**

| | | | | | |
|---|---|---|---|---|---|
| Y N | Aspirin | Y N | Dental Anesthetics | Y N | Penicillin |
| Y N | Any Metals | Y N | Erythromycin | Y N | Tetracycline |
| Y N | Codeine | Y N | Latex | Y N | Other |

Please list any other drugs/materials that you are allergic to: _____

_____

## 6 Dental History

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

_____

_____

Have you ever had or been evaluated for orthodontic treatment? ☐ Yes ☐ No

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Have you ever had an injury to your: Mouth Teeth Chin

Do you have any speech problems? _____

Do you generally breathe through your mouth?

If yes, please circle: While awake? While Asleep?

Do you have any missing or extra permanent teeth? ☐ Yes ☐ No

Have you ever taken Fosamax? ☐ Yes ☐ No

Have you ever taken Phen-Fen? ☐ Yes ☐ No

Do you smoke or use tobacco in any form? ☐ Yes ☐ No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

**Signature** **Date**

**Thank you for filling out this form completely.**

This office reserves the right to verify the credit status of potential patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

_____

**Signature** **Date**

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 payment of the group insurance benefits (otherwise payable to me) directly to this office.

_____

**Signature** **Date**

**OFFICE USE ONLY**

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

**Doctor's Comments:** **Initials:** _____ **Date:** _____

_____

_____

_____