

Date: _____

PRODUCING SMILES!

ORTHODONTICS

Murray Dickson, DMD, MBA

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Welcome to our office!

Thank you for choosing our orthodontic team!

To aid us in better communication, please fill out this form completely.



Patient's Name: First _____ MI _____ Last _____

Patient's E-mail Address : _____

Patient's Address: _____ City _____ State _____ Zip _____

DOB _____ SSN _____ Married _____ Male _____ Female _____

Home # _____ Mobile/Pager # _____ Work # _____

Employer Name: _____ City _____

How long there? _____ Occupation _____ Best time to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Spouse Name: _____ DOB _____

Employer Name: _____ Work # _____

Dentist Name: _____ Date of Last Cleaning: _____

In the Event of an Emergency, Please Contact:

Name: _____ Relationship to Patient _____

Home # _____ Mobile/Pager # _____ Work # _____

Mother and father's name if child: _____

Responsible Party IF DIFFERENT FROM PATIENT

Name: _____ Relationship to Patient _____

E-mail Address : _____

DOB _____ SSN _____ Male _____ Female _____

Home # _____ Mobile/Pager # _____ Work # _____

Employer Name: _____ City _____

Primary Insurance (Please provide insurance card for us to copy)

Insurance Company: _____ Address: _____

Insurance Company Phone: _____ Group Number: _____ Policy Number: _____

Name of Insured (as it appears on the card): _____

Relationship to Patient: _____ DOB _____ SSN _____

Employer Name: _____ City _____

Secondary Insurance (Please provide insurance card for us to copy)

Name of Insured (as it appears on the card): _____

Relationship to Patient: _____ DOB _____ SSN _____

Employer Name: _____ City _____

MEDICAL HISTORY

Do you have a personal physician? Yes_____ No_____

Physician's Name: _____

Phone # _____ Date of last visit: _____

Your current physical health is: Good _____ Fair _____ Poor _____

Are you currently under the care of a physician? Yes_____ No_____

If yes, please explain: _____

For Women: Are you pregnant? _____ Nursing? _____

List all medications that you are currently taking (prescription and non-prescription)

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 / 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 Treatments |
| Y N | Drug / Alcohol Abuse | Y N | Rheumatic / Scarlet Fever |
| Y N | Emphysema | Y N | Severe / Freq. Headaches |
| Y N | Epilepsy / Seizures / Fainting | Y N | Shingles |
| Y N | Fever Blisters / Herpes | Y N | Sickle Cell Disease |
| Y N | Glaucoma | Y N | Sinus Problems |
| Y N | Heart Attack / Stroke | Y N | TMJ Discomfort |
| Y N | Heart Murmur | Y N | Tuberculosis (TB) |
| Y N | Heart Surgery / Pacemaker | Y N | Ulcers / Colitis |
| | | Y N | Veneral Disease |

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

List any drugs and/or materials that you are allergic to:

Habits:

- | | | | |
|-----|-------------------------|-----|-----------------|
| Y N | Thumb or Finger Sucking | Y N | Speech Problems |
| Y N | Mouth Breathing | Y N | Nail Biting |
| Y N | Grinding Teeth | | |

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 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____

Do you like your smile? Yes _____ No _____ Gums ever bleed? Yes _____ No _____

Have you ever had an injury to your: Mouth Teeth Chin (please circle)

Do you have any speech problems: _____

Do you generally breathe through your mouth? Yes _____ No _____

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

Do you have any missing or extra permanent teeth? 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 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

This office reserves the right to verify the credit of potential patients and / or parents of 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 agencies.

Signature Date

This office accepts insurance payments. I understand I am responsible for payments of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

Signature Date

I understand and have been offered a Producing Smile! Notice of Privacy Practices that provides a more complete description of information uses and disclosures; that I have the right to review the notice prior to signing this acknowledgement; that Dr. Alan Jones reserves the right to change its notice and practices.

X _____
Signature of Patient or Date Witness
Authorized Representative

____ Good faith attempt has been made to provide the patient with our Notice of Privacy Practices.

X _____
Producing Smiles! Employee Signature Date Witness