PRODUCING SMILES! ORTHODONTICS
DR. MURRAY DICKSON
1111 GLENEAGLES DRIVE, SUITE B
HUNTSVILLE, AL 35801
(256) 882-9483

Date:_____

PATIENT INFORMATION

First Name:_____ MI:___ Last Name:_____
Nickname:_____ DOB:_____ SS#:_____
Address:_____
City:_____ State:_____ Zip:_____
Phone:_____Married_____ Male:_____ Female:_____

PARENT INFORMATION(Please complete if patient is a minor)

Father's Name:_____
DOB:_____ SS#:_____
Address(if different from patient's):_____
City:_____ State:_____ Zip:_____
Home Phone:_____Cell:_____Work:_____
Email:_____
Employer:_____ City_____ State:____

Mother's Name:_____
DOB:_____ SS#:_____
Address(if different from patient's):_____
City:_____ State:_____ Zip:_____
Home Phone:_____Cell:_____Work:_____
Email:_____
Employer:_____ City_____ State:____

RESPONSIBLE PARTY

Name:_____
Relationship to Patient:_____
Address:_____
City:_____ State:_____ Zip:_____
Home Phone:_____Cell:_____Work:_____
Email:_____
Employer:_____ City_____ State:____

INSURANCE INFORMATION

Insurance Company:_____Phone:_____
Claims Address:_____
City:_____ State:_____ Zip:_____
Name of Insured(as it appears on the card):_____
DOB:_____ SS#:_____ Relationship to Patient:_____
Employer:_____ City_____ State:____

MEDICAL HISTORY

Are you presently under physician's care? Yes_____ No_____
If yes, please explain:_____
Physician's Name:_____ Phone:_____
List current medications:_____
_____
List any allergies:_____

Have you had any of the following?

Y N Joint Swelling
Y N Bone Disorders
Y N Heart Trouble
Y N Mitral Valve Prolapse
Y N Arthritis
Y N Thyroid Problems
Y N Diabetes
Y N Emotional/Mental Problems
Y N Brain Injury
Y N Kidney or Liver Problems
Y N Joint Prosthesis
Y N Tuberculosis
Y N Anemia
Y N Epilepsy(seizures)
Y N Prolonged bleeding
Y N Faintness/Dizziness
Y N Tonsils/Adenoids Removed
Y N Sore Throats/Earaches
Y N Asthma
Y N Drug/Alcohol Abuse
Y N Rheumatic/Scarlet Fever
Y N Fever Blisters/Herpes

List any other serious illnesses:_____
_____

DENTAL HISTORY

Name of Dentist:_____
Please circle what applies to patient:

Y N Any injuries to face,mouth,teeth?
Y N Thumb, finger, or lip sucking?
Y N Grinding or Clenching teeth?
Y N Nail biting
Y N Mouth breathing
Y N Speech problems
Y N Any missing or extra permanent teeth?
Y N Any pain, clicking, or popping on opening/closing mouth?
Y N Has an orthodontist been consulted previously?
Y N Adolescent Females: Has menstruation begun? Month/Year_____

What would you like to have orthodontic treatment accomplish?_____
_____
Patient's attitude toward orthodontic treatment(circle one):
Very motivated_____ Will cooperate if needed_____ Not Motivated_____

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. Please note that we cannot accept divorce decrees as assignments of responsibility for a child's orthodontic bills. The parent who signs the financial contract will be responsible for payment and seek any reimbursement from the other parent.
I, the undersigned, agree to pay for attorney fees and other costs of collection in the event it becomes necessary to use attorney services to secure payment of this account.

_____
Signature of Patient or of Parent/Guardian(if Patient is a Minor)