STORIE & STURGILL ORTHODONTICS

ADULT

Personal Information

Name:_____
Last First MI

☐Mr. ☐Mrs. ☐Ms. ☐Dr.

Nickname:_____ ☐ Male ☐ Female

Birthdate:____/____/_____Age:_____SS#: _____

Home Address:_____

_____
City State Zip

Hm#: (_____)_____ Cell #:(_____)_____

Wk#: (_____)_____ Ext: _____

Email: _____

Preferred contact: ☐ Home ☐ Cell ☐ Work ☐ Email

Employer: _____

Employer's Address:_____

How long there? _____ Occupation:_____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Married, Spouse's Name:_____

Spouse Phone Number: _____

Dental Insurance

Orthodontic Benefit? ☐ Yes ☐ No ☐Unsure

Insurance Co. Name: _____

Insurance Co Phone #: (_____) _____

Group # (Policy/Plan #): _____

Secondary Dental Insurance

Orthodontic Benefit? ☐ Yes ☐ No ☐Unsure

Insurance Co. Name: _____

Insurance Co Phone #: (_____) _____

Group # (Policy/Plan #): _____

If the primary insured person for either insurance(s) is someone other than you, please provide the following:

Insured's Name: _____

Insured's Relation: _____

Insured's Birthdate: ____/____/_____ SS #:_____

Insured's Employer: _____

Are you responsible for the account? ☐ Yes ☐ No

If no, please name:_____

Medical History

Do you have a primary care physician? ☐ Yes ☐ No

Physician's Name:_____

Phone#: (_____)_____ Last Visit: _____

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

Height: _____ Weight: _____

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

If yes, please explain: _____

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

Do you use recreational drugs? ☐ Yes ☐ No

Have you had any metal rods, pins, or implants? ☐ Yes ☐ No

Please list any prescriptions or over-the-counter drugs you take:

_____

_____

_____

Have you ever taken Fosamax, Actonel, Boniva, or any other bisphosphonate? ☐ Yes ☐ No

Have you ever had any of the following (circle)

Y	N	AIDS/HIV	Y	N	Hepatitis
Y	N	Alcohol/Drug Abuse	Y	N	Herpes/Fever Blisters
Y	N	Anemia	Y	N	High Blood Pressure
Y	N	Arthritis	Y	N	Kidney Problems
Y	N	Artificial Joints/Valves	Y	N	Liver Disease
Y	N	Asthma	Y	N	Low Blood Pressure
Y	N	Blood Transfusion	Y	N	Lupus
Y	N	Cancer/Chemotherapy	Y	N	Mitral Valve Prolapse
Y	N	Colitis	Y	N	Pacemaker
Y	N	Congenital Heart Defect	Y	N	Psychiatric Problems
Y	N	Diabetes	Y	N	Radiation Treatment
Y	N	Difficulty Breathing	Y	N	Rheumatic/Scarlet Fever
Y	N	Emphysema	Y	N	Seizures
Y	N	Epilepsy	Y	N	Shingles
Y	N	Fainting Spells	Y	N	Sickle Cell Disease/Trait
Y	N	Frequent Headaches	Y	N	Sinus Problems
Y	N	Glaucoma	Y	N	Stroke
Y	N	Hay Fever	Y	N	Thyroid Problems
Y	N	Heart Attack/Surgery	Y	N	Tuberculosis (TB)
Y	N	Heart Murmur	Y	N	Ulcers
Y	N	Hemophilia/Blood Disorder	Y	N	Venereal Disease

Other medical condition(s): _____

_____

_____

Medical History

Do you have any allergies? ☐ Yes ☐ No If Yes, please **circle** from the list below or write in the space provided:

Aspirin Metals/Nickel Advil/NSAIDs Penicillin Latex Codeine

Other allergies and reaction: _____

_____

Women Only:

Are you pregnant? ☐ Yes ☐ No If yes, week #: _____ Are you taking birth control pills? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Dental History

General Dentist: _____

Last Visit: _____ Reason for Visit: _____

Other dental specialists you see routinely (i.e. Periodontist): _____

Orthodontic History

List concerns you have about your smile and/or bite:

_____

_____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Have you ever had orthodontic treatment? ☐ Yes ☐ No If Yes, please explain: _____

Have you ever been evaluated by an orthodontist?	☐Yes ☐ No	Have you ever been treated for TMJ/TMD?	☐ Yes ☐ No
Anyone in your family had jaw surgery to correct his/her bite?	☐Yes ☐ No	Do you experience discomfort/pain in your jaw joints?	☐ Yes ☐ No
History of facial birth defects or cleft palate?	☐Yes ☐ No	Does your jaw routinely pop or click?	☐ Yes ☐ No
Have you ever been diagnosed with sleep apnea?	☐Yes ☐ No	Has your jaw ever locked closed or open?	☐ Yes ☐ No
Have you ever been diagnosed with speech problems?	☐ Yes ☐ No	Do you have frequent headaches/migraines?	☐ Yes ☐ No
Do you commonly snore?	☐ Yes ☐ No	Do you wear a mouth guard at night?	☐ Yes ☐ No
Do you grind or clench your teeth?	☐ Yes ☐ No	Do you experience pain/ringing in your ears?	☐ Yes ☐ No
Have you ever had major trauma/injury to your face, jaw, teeth, or mouth?	☐ Yes ☐ No	Do you typically breathe through your (circle one)	Mouth Nose

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 Storie & Sturgill Orthodontics. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information, including records of examination, diagnosis, and treatment rendered, to my insurance company.

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 that 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. I understand that Storie & Sturgill Orthodontics reserves the right to verify the credit status of patients and/or their parents 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.

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, the ADA, and the AAO.

_____

Signature Date

Office Use Only

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

TC Signature/Date: _____ Doctor Signature: _____