The benefits of a happy, healthy smile are immesurable! A beautiful smile is a wonderful asset.

Please fill out this form completely. The better we communicate, the better we can care for you.

COASTLINE ORTHODONTICS

1. ABOUT YOU

Today's Date: _____ E-Mail Address: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ ☐ Male ☐ Female Birthday: ___/___/___ Age: _____ SSN: _____

Home Address: _____
APT/CONDO# CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm#: _____ Pager/Other #: _____ Wk#: _____ Ext: _____ DL#: _____

Employer: _____ Employer's Address: _____

Employment date: ___/___/___ Occupation: _____

Where and when are the best times to reach you? _____

Whom may we thank for referring you? _____

Have any other family members been seen or treated by us? _____

General Dentist: _____ Last Visit Date: _____

2. SPOUSE INFORMATION

His/Her Name: _____

Employer: _____

Wk#: _____ Ext: _____ SSN: _____

Birthday: ___/___/___

Person Responsible for Account: _____

Wk#: _____ Ext: _____ Hm#: _____

Billing Address: _____

Relation: _____ SSN: _____

Employer: _____ DL#: _____

3. ORTHODONTIC INSURANCE

PRIMARY

Orthodontic 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 SSN:** _____

Insured's Employer: _____

SECONDARY

Orthodontic 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 SSN:** _____

Insured's Employer: _____

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

His/Her Name: _____ Relation: _____

Wk#: _____ Hm#: _____

PLEASE CONTINUE ON THE NEXT PAGE

4. MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____ Phone#: _____ Date of last visit: _____

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 taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week#: _____ Are you nursing? ☐ Yes ☐ No

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

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

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

Are you allergic to any of the following?

Y N Aspirin	Y N Codeine	Y N Erythromycin	Y N Penicillin
Y N Any Metals / Plastics	Y N Dental Anesthetics	Y N Latex	Y N Tetracycline
			Y N Other

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

5. 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 **Do you like your smile?** ☐ Yes ☐ No **Do your gums ever bleed?** ☐ Yes ☐ No

Have you ever had an injury to your: **Mouth** **Teeth** **Chin** *(Please Circle)*

Do you have speech problems? _____

Do you generally breathe though your mouth? ☐ Yes ☐ No
If yes, please circle: While Awake? While Asleep?

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

Have you ever taken Phen-Fen? ☐ Yes ☐ No
Also known as Redux or Pandimin

If yes, when? _____

THANK YOU FOR FILLING OUT THIS FORM COMPLETELY

This office reserves the right to verify the credit status of potential patiets 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 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.

SIGNATURE DATE

*I understand that the information that I have given today is correct to the best of my knowledge. I do 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

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____