

WELCOME TO MERGEN ORTHODONTICS

PATIENT INFORMATION

*Patient's Name: (last) _____ (first) _____ (middle) _____

Preferred Name: _____

*Birth date: _____ Age: _____ Gender: _____ female _____ male

Hobbies / sports / musical instrument: _____

Attends school at: _____ Grade: _____

Brothers and / or sisters: (names and ages) _____

Other family members treated here: _____

WHAT is the primary reason for your visit: _____

WHY did you select our office for treatment: _____

WHO may we thank for referring you to our office: _____

CUSTODIAL PARENT(S) OR GUARDIAN(S)

Name(s): _____ Relationship to patient: _____

Spouse: _____ Marital status: _____

*Address: _____ City: _____ Zip: _____

Phone: (home) _____ (work) _____ (cell) _____

E-mail address: _____

Address of patient (if different than parent or guardian above):

Address: _____ City: _____ Zip: _____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT

Name: (last) _____ (first) _____ (middle) _____

S.S.N.: _____

Employer: _____ How many years: _____ City: _____

Address and phone of responsible person (if different from parent or guardian above):

Address: _____ City: _____ Zip: _____

Phone: (home) _____ (work) _____ (cell) _____

ORTHODONTIC INSURANCE COVERAGE(S)

Insurance coverage for **orthodontic** treatment? _____ (yes) _____ (no) Dental? _____ (yes) _____ (no)

Primary Policy Holder For Orthodontic Insurance:

*Name: (last) _____ (first) _____ (middle) _____

*S.S.N. : _____

*Birth Date: _____

*Employed by: _____ City: _____

*Dental Insurance Company: _____ Plan: _____

*Group No: _____ *Policy No: _____

Secondary Policy Holder For Orthodontic Insurance:

*Name: (last) _____ (first) _____ (middle) _____

*S.S.N. : _____

*Birth Date: _____

*Employed by: _____ City: _____

*Dental Insurance Company: _____ Plan: _____

*Group No: _____ *Policy No: _____

***PLEASE MAKE SURE THAT THESE ITEMS ARE FILLED IN SO THAT WE CAN FILE YOUR ORTHODONTIC INSURANCE FOR YOU**

PATIENT MEDICAL AND DENTAL HISTORY

PATIENT MEDICAL HISTORY

- Y N Birth defects or hereditary problems?
Y N Liver problems?
Y N Kidney problems (jaundice, etc.)?
Y N Lung problems (asthma, etc.)?
Y N Heart problems (defects, strokes, heart attack, high blood pressure, etc.)?
Y N Heart valve repair?
Y N Heart murmur?
Y N Neurological problems?
Y N Epilepsy or seizures?
Y N Ears, nose, throat conditions?
Y N Diabetes?
Y N Polio, mononucleosis, or pneumonia?
Y N Tuberculosis (TB)?
Y N Hepatitis?
Y N AIDS or HIV positive?
Y N Allergies (Aspirin, Advil, Ibuprofen, Latex, Acrylic, Nickel Metals)

Please list any allergies: _____

If you have **answer yes** to any items above, please describe the problem.

Please list any medications that you are currently taking, how long and for what: _____

Physicians name: _____ City: _____

General Dentists name: _____ City: _____

PATIENT DENTAL HISTORY

- Y N Baby teeth removed that were not lost?
Y N Permanent or supernumerary (extra) teeth removed?
Y N Chipped or injured any teeth?
Y N Thumb or finger sucking habit? Until what age? _____ Still present? _____
Y N Mouth breathing (breathing mainly through mouth & not nose)?
Y N Grinding or clenching teeth? _____ night _____ day _____ both
Y N Jaw pain or clicking? _____ right _____ left _____ both

PATIENT PROFILE

- Y N Does patient follow directions well?
Y N Does patient brush and floss routinely?
Y N Does patient have a learning disability or need extra help with directions?
Y N Is patient sensitive or self-conscious about their teeth or smile?
Y N Is the patient interested in improving their smile?

I have read and understand the above questions. If there are any changes later to this medical / dental status, I will inform Mergen Orthodontics. I have read the *Notice of Privacy Practices (HIPAA)* for Mergen Orthodontics and I understand that I may obtain a copy if I so desire.

Signature (parent or guardian): _____ Date: _____