UPDIKE ORTHODONTICS

Welcome

The benefits of a happy, healthy smile are immeasurable. Our goal is to help you reach and maintain optimal oral health. Please fill out this form completely. The better we communicate the better we can care for you

About You

Today's Date_____

E-mail Address: _____

Name: _____
Last First Mi Mr. Mrs. Ms Dr

I prefer to be called_____ ■Male ☐ Female

Birthdate: ___/___/___ Age: ___ SS#_____

Home Address: _____

_____
City State Zip

☐ Single ☐Married ☐Divorce ☐Widowed ☐Separated

Hm #: _____ Cell/Other: _____

Wk #: _____ Ext: _____ DL #: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous/Present Dentist: _____

Person Responsible for Account: _____

Spouse Information

His/Her Name: _____

Employer: _____

Wk#: _____ Ext: _____ SS#: _____

Relative or Friend not living with you.

His/her Name:_____

Wk #: _____ Hm #: _____

Orthodontic Insurance

Primary

Orthodontic Coverage? ☐ Yes ☐ No
Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address_____

_____
City State Zip

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

_____
City State Zip

Secondary

Orthodontic Coverage? ☐ Yes ☐ No
Dental Coverage? ☐ Yes ☐ No

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

_____
City State Zip

Payment is due in full at the time of treatment
(unless prior arrangements have been approved.)

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. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____
Signature Date

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 physician? ☐Yes ☐No
Please explain: _____
Do you smoke or use tobacco in any other form? ☐Yes ☐No
Have you had any metal rods, pins or implants? ☐Yes ☐No
Are you taken any prescription/over the counter drugs? ☐
Please list each one: _____
Have you ever taken Phen-Fen? ☐Yes ☐No
Also known as Redux or Pondimin.
If so when: _____
For women: Are you taken birth control pills? ☐Yes ☐No
Are you Pregnant? ☐Yes ☐No Weeks #: _____
Are you nursing? ☐Yes ☐No

Have you ever have any od the following diseases or medical problems:

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

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

Are you allergic to any of the following?

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Jewelry/Metals
Y N Latex
Y N Penicilin
Y N Tetracycline
Y N Other

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

Dental History

What are the main concerns that you would like orthodontics to accomplish?

_____
_____

Have you ever 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:
Do you still have wisdom teeth? ☐ Yes ☐ No
Have you ever had an injury to your: ☐Mouth ☐Teeth ☐Chin
Do you have any speech problems?
Do you generally breathe through our mouth? ☐ Yes ☐ No
If yes, please circle: ☐While awake? ☐While asleep?
Do you have any missing or extra permanent teeth? ☐ Yes ☐ No
Are you happy with the way your smile looks? ☐ Yes ☐ No
If not, what would you change?_____
_____
_____

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

OFFICE USE ONLY

I have verbally reviewed the medical/dental information with the patient named herein.
Initials:_____ Date: _____
Doctor's Comments:
_____
_____
_____

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

MEDICAL HISTORY UPDATE

Has there been any change in your health status since your last visit? ☐ Yes ☐ No
If yes, please explain:_____

_____
Patient Signature Date

_____
Dentist Signature Date