Braces

Tallahassee Orthodontic Care

D. B. Snead, D.M.D.

About You

Today's Date: _____

Name: _____

MI MR MRS MS DR

I prefer to be called: _____ ☐ Male ☐ Female

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

Home Address: _____

City, State, Zip _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm# _____ Pager/Other # _____

Wk# _____ Ext. _____

E-Mail Address: _____

Employer: _____

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: _____

General Dentist: _____

Last Cleaning Visit Date: _____

Family Information

Spouse's Name _____

Employer: _____

Wk# _____ Ext. _____

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

Dependent's Names: Birthdates: Age:

_____

_____

_____

Name of person responsible for account: _____

Orthodontic Insurance

Primary

Orthodontic Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

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

Insured's Name: _____

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

Insured's Employer: _____

Secondary

Orthodontic Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

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

Insured's Name: _____

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

Insured's Employer: _____

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

His / Her Name: _____

Wk #: _____ Ext: _____ Hm#: _____

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: _____ Date of last visit _____

Do you need to be premedicated with antibiotic prescription before dental treatment? ☐ Yes ☐ No

MEDICAL HISTORY *continued*

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

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

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 Dental Anesthetics	Y N Penicillin
Y N Any Metal/Plastic	Y N Erythromycin	Y N Tetracycline
Y N Codeine	Y N Latex	Y N Other

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

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 any speech problems? _____

_____

Do you generally breathe through your mouth?
Y N Awake? Y N Asleep?
(PLEASE CIRCLE)

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

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 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

THANK YOU FOR FILLING OUT THIS FORM COMPLETELY.

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

_____

Signature Date

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

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

Doctor's Comments: Initials:_____ Date:_____

_____

_____

_____