Hidden Smiles
ORTHODONTIC STUDIO
Discover Your Hidden Smile

Patient Information:

Name:_____
FIRST MIDDLE LAST

Date Of Birth: _____ /_____ / _____ Phone Number:_____

Address: _____
NO. STREET CITY STATE ZIP CODE

Names/Ages of siblings if a minor:_____

_____

Responsible Party Information:

Name:_____ ❑ Married ❑ Divorced ❑ Single
FIRST MIDDLE LAST

Custodial Parent: ❑ Mother ❑ Father ❑ Both E-mail Address: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Employer:_____ Occupation: _____

Social Security #: _____-_____- _____ Date of Birth:_____/_____/_____ Work Phone: (____)_____

Spouse's Name:_____
FIRST MIDDLE LAST

Employer:_____ Occupation: _____No. Years Employed:_____

Social Security #: _____-_____- _____ Date of Birth:_____/_____/_____ Work Phone: (____)_____

Dental Insurance Information:

Primary Policy Holder: _____ Secondary Policy Holder:_____

SS# of Policy Holder: ____-____-_____ Date of Birth: ____/____/___ SS# of Policy Holder: ____-____-_____ Date of Birth: ____/____/___

Insurance Company:_____ Insurance Company: _____

Insurance Group/Policy#: _____ Insurance Group/Policy#:_____

Address: _____ Address: _____

I hereby authorize release of any information to other health care providers, insurance companies, and business associates, including personal health information as well as administrative date which is not strictly dental or medical in nature. I additionally authorize payment directly to Hidden Smiles Orthodontics of the insurance benefits otherwise payable to me. I am giving consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. I certify that the above information is complete and true to the best of my knowledge.

Signature _____ Date: _____

Patient's Dentist _____ Phone: (____) _____ Last Visit: _____

What is patient's primary concern: _____

Patient's Physician: _____ Phone: (____) _____ Last Visit: _____

Is patient presently being treated by a physician? ❑ Yes ❑ No Why? _____

- ❑ ADD/ADHD
- ❑ Anemia
- ❑ Any TMJ History
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Problems
- ❑ Breathing Problems
- ❑ Chewing Problems
- ❑ Cold Sores
- ❑ Concussion
- ❑ Convulsions/Seizures
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Facial Pain
- ❑ Frequent Colds
- ❑ Grinding/Clenching
- ❑ Gum Problems
- ❑ Hearing Problem
- ❑ Heart Murmur
- ❑ Immune Deficiency
- ❑ Injury to Teeth/Jaws
- ❑ Jaw Popping
- ❑ Latex Allergy
- ❑ Lip Biting
- ❑ Metal Allergy
- ❑ Mitral Valve Prolapse
- ❑ Nail Biting
- ❑ Nervous Disorder
- ❑ Pre Medication Required
- ❑ Presently Suck Thumb/Finger
- ❑ Problems Opening/Closing
- ❑ Rheumatic Fever
- ❑ Seasonal Allergy
- ❑ Severe Headaches
- ❑ Sinus Problems
- ❑ Smoke Cigarettes/Cigars
- ❑ Thyroid/Hormonal Imbalance
- ❑ Tongue Thrusting
- ❑ Tuberculosis
- ❑ Ulcers

Other Allergy – List: _____ Major Surgery: _____

Has Patient ever had orthodontic treatment or worn a retainer? ❑ Yes ❑ No

Does anyone else in the family have a similar orthodontic problem? ❑ Yes ❑ No If so, who: _____

Names of Daily Medications: _____

TMJ Screening:

1. Do you have any facial, ear or jaw pain? ❑ Yes ❑ No
2. Does your jaw pop or click when you chew, yawn or open and close your mouth? ❑ Yes ❑ No
3. Do you get headaches or neck aches frequently? ❑ Yes ❑ No

Is there any other information about the patient's health we should know? _____

_____

Whom may we thank for referring you to our office?
Please check all that apply:

❑ My Dentist ❑ Team Member At My Dentist Office ❑ Selected Doctor from Insurance Provider List

❑ Website ❑ Invisalign® Website ❑ Yellow Page Ad ❑ Newspaper Ad in: _____

My Friend/Relative Referred Me (list name(s)): _____

_____

Other (please specify): _____

_____

_____

Signature _____ Date: _____