TAYLOR
ORTHODONTICS

Thank you for providing this important information to help us serve you best. If you have any questions or need assistance, just ask. We're happy to help!

Patient Information

NAME _____ PREFERRED NAME _____ M F

DATE OF BIRTH _____ SSN _____

HOME PHONE _____ CELL PHONE _____

ADDRESS _____ EMAIL _____

CITY _____ STATE _____ ZIP _____ HOW LONG AT THIS ADDRESS? _____

EMPLOYER _____ OCCUPATION _____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

WORK PHONE _____ NUMBER OF YEARS EMPLOYED _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

MARITAL STATUS ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐ SINGLE

Spouse Information

(IF APPLICABLE)

SPOUSE'S NAME _____ DATE OF BIRTH _____ SSN _____

EMPLOYER _____ OCCUPATION _____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

WORK PHONE _____ NUMBER OF YEARS EMPLOYED _____

CELL PHONE _____ EMAIL _____

Primary Insurance Information

☐ CHECK HERE IF NO ORTHODONTIC COVERAGE WILL BE APPLIED

INSURANCE COMPANY _____ INSURANCE PHONE NUMBER _____

EMPLOYER/GROUP NAME _____ GROUP NUMBER _____

SUBSCRIBER/EMPLOYEE _____ SUBSCRIBER ID/SSN _____

DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

Secondary Insurance Information

☐ CHECK HERE IF NO SECONDARY INSURANCE

INSURANCE COMPANY _____ INSURANCE PHONE NUMBER _____

EMPLOYER/GROUP NAME _____ GROUP NUMBER _____

SUBSCRIBER/EMPLOYEE _____ SUBSCRIBER ID/SSN _____

DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

Emergency Contact Information

NAME _____ RELATIONSHIP TO PATIENT _____

HOME PHONE _____ CELL PHONE _____

Please take a moment to complete the reverse side of this form.

Medical History

PHYSICIAN _____ PHONE _____ DATE OF LAST EXAM _____

	Y	N
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. HAVE YOU BEEN HOSPITALIZED FOR ANY SURGICAL OPERATIONS OR SERIOUS ILLNESS IN THE PAST FIVE YEARS?	☐	☐
3. ARE YOU TAKING MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?	☐	☐
4. DO YOU USE TOBACCO?	☐	☐
5. ARE YOU AWARE OF BEING ALLERGIC TO ANY MEDICATIONS OR SUBSTANCE, INCLUDING METALS?	☐	☐
6. FEMALES ONLY: ARE YOU PREGNANT, OR THINK YOU MAY BE?	☐	☐
7. EVER TAKEN BISPHOSPHONATES (EX: FOSAMAX) FOR OSTEOPOROSIS?	☐	☐

IF YES, WHAT MEDICATION(S) ARE YOU TAKING?

_____

IF YES, WHAT?

_____

IF YES, SPECIFY _____

8. PLEASE CHECK ALL THAT APPLY:

HAY FEVER/ALLERGIES	☐	LEUKEMIA	☐
COLD SORES	☐	KIDNEY/LIVER DISEASE	☐
MIGRAINES	☐	ANEMIA	☐
DIABETES/GLAUCOMA	☐	CANCER	☐
RHEUMATIC FEVER	☐	JOINT REPLACEMENT/IMPLANT	☐
AIDS OR HIV INFECTION	☐	HEPATITIS/JAUNDICE	☐
CARDIAC PACEMAKER	☐	STOMACH TROUBLES/ULCERS	☐
ASTHMA (INHALER)	☐	SINUS PROBLEMS	☐
FAINTING/SEIZURES	☐	STROKE	☐
THYROID PROBLEM	☐	RADIATION THERAPY	☐
HIGH/LOW BLOOD PRESSURE	☐	RESPIRATORY PROBLEMS	☐
HEART TROUBLE	☐	BONE DISORDER	☐
EPILEPSY/CONVULSIONS	☐	OSTEOPENIA/OSTEOPOROSIS	☐
TAKING MEDICATION:	☐	REMOVAL OF ADENOIDS/TONSILS	☐

IF SO, SPECIFY: _____

_____

Dental History

DENTIST _____

DATE OF LAST CLEANING _____

	Y	N
1. ARE YOU ANXIOUS OR NERVOUS ABOUT DENTAL TREATMENT?	☐	☐
2. DO YOU REQUIRE PREMEDICATION FOR DENTAL TREATMENT?	☐	☐
3. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?	☐	☐
4. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	☐	☐
5. HAVE YOU HAD ANY HEAD, NECK, OR JAW INJURIES?	☐	☐

IF YES, PLEASE DESCRIBE:

_____

6. DO YOU HAVE ANY ONGOING PROBLEMS IN YOUR JAW WITH:		
A. CHRONIC CLICKING OR POPPING?	☐	☐
B. PAIN?	☐	☐
C. DIFFICULTY OPENING OR CLOSING?	☐	☐
D. DIFFICULTY IN CHEWING?	☐	☐
7. DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐
8. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	☐	☐
9. HAVE YOU EVER HAD SPEECH THERAPY?	☐	☐

IF YES, PLEASE DESCRIBE:

_____

	Y	N
10. IS THERE ANY OUTSTANDING DENTAL TREATMENT TO BE COMPLETED?	☐	☐
11. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING AND FLOSSING YOUR TEETH?	☐	☐
12. DO YOU HAVE ANY OF THE FOLLOWING ORAL HABITS:		
A. NAIL BITING?	☐	☐
B. THUMB SUCKING?	☐	☐
C. TONGUE THRUST WHILE SWALLOWING?	☐	☐
D. MOUTH BREATHING?	☐	☐

IF YES, PLEASE DESCRIBE:

_____

13. HOW MANY TIMES A DAY DO YOU BRUSH? _____

14. **PLEASE CHECK THE BOXES BELOW WHICH DESCRIBE THE PROBLEM(S) FOR WHICH YOU ARE SEEKING TREATMENT:**

CROWDING	☐	**MISSING TEETH**	☐
EXTRA SPACE	☐	**EXTRA PERMANENT TEETH**	☐
TEETH STICK OUT TOO FAR	☐	**TEETH ERUPTING IN THE WRONG POSITION**	☐
TMJ PROBLEMS	☐		
POOR BITE RELATIONSHIP	☐	**OTHER:** _____	

	Y	N
15. HAS THE PATIENT HAD AN ORTHODONTIC EVALUATION OR TREATMENT BEFORE?	☐	☐

IF SO, WHEN AND BY WHOM?

_____

Authorization and Release

TO THE BEST OF MY KNOWLEDGE THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES TO THE PATIENT'S MEDICAL STATUS. I GIVE TAYLOR ORTHODONTICS PERMISSION TO PERFORM THE NECESSARY DENTAL SERVICES THAT THE PATIENT MAY NEED.

PRINT NAME _____

DATE _____

PATIENT SIGNATURE