New Patient Information

Who's the Patient?

Patient Name: ______________________ Date of Birth: ____________ Age: _____ ☐ Female ☐ Male

Address: ______________________ City/State: ____________ Zip code: ________

Phone Numbers - Home: ____________ Work: ____________ Cell: ____________

e-mail: ____________ Hobbies/Interests: ______________________

Occupation: ____________ Employer: ______________________

If student, what grade? ________ Which school? ______________________

Who's the Responsible Party?

The Responsible Party is our primary communications contact & the person responsible for the account.

Relationship to the Patient: ☐ Self (skip to insurance) ☐ Mother ☐ Father ☐ Other: ____________

Name: ______________________ e-mail: ____________

Address: ______________________ City/State: ____________ Zip code: ________

Phone Numbers – Home: ____________ Work: ____________ Cell: ____________

Occupation: ____________ Employer: ______________________

Do you have Dental Insurance?

If so, we'll find out if you have orthodontic coverage and benefits!

(if you've already supplied your insurance information to us, simply provide your insurance card to the front desk so we can copy it and skip to final questions)

Primary Insurance

Insurance Co/Plan: ______________________ Phone (on card): ____________

Policy Holder Name: ______________________ Date of Birth: ____________ SS#: ____________

Member ID#: ____________ Group ID#: ____________ Employer: ____________

Is there other dental insurance you'd like us to check on? If yes, please provide details below and your insurance card to the front desk.

Secondary Insurance

Insurance Co/Plan: ______________________ Phone (on card): ____________

Policy Holder Name: ______________________ Date of Birth: ____________ SS#: ____________

Member ID#: ____________ Group ID#: ____________ Employer: ____________

Final Questions

How did you hear about our office? ______________________

What orthodontic concerns do you have? ______________________

What do you value most in your orthodontist? ______________________

Is there anything else you would like us to know? ______________________

Dental History

Dentist: ______________________________ Date of last cleaning: ______________________

Address: ______________________________ Phone: ______________________

How often do you brush? ______________________ floss? ______________________

Check any boxes that apply to the patient:

- ☐ ever sucked a thumb or finger? Until what age: ________

- ☐ previous orthodontic care
- ☐ clicking or popping jaw
- ☐ grinding or clenching teeth
- ☐ jaw pain
- ☐ sore facial muscles
- ☐ jaw/facial injuries
- ☐ dental/tooth injuries
- ☐ loose teeth or broken fillings
- ☐ sores or growths in the mouth
- ☐ bleeding gums
- ☐ sensitivity to hot or cold
- ☐ mouth breathing

Please describe any dental conditions checked above: ______________________________

____

Do you have any dental problems not listed above? ☐ Yes ☐ No

If yes, please describe: ____

Medical History

Check any boxes that apply to the patient:

- ☐ currently under a physician's care? Describe: ______________________________
- ☐ currently taking medications? Describe: ______________________________
- ☐ any allergies to medication? Describe: ______________________________
- ☐ any contact allergies (latex, nickel, etc.)? Describe: ______________________________

- ☐ congenital heart problems
- ☐ heart murmur
- ☐ rheumatic fever
- ☐ tuberculosis
- ☐ abnormal bleeding
- ☐ high/low blood pressure
- ☐ diabetes
- ☐ HIV/AIDS
- ☐ hepatitis
- ☐ liver problems
- ☐ kidney problems
- ☐ arthritis
- ☐ epilepsy/seizures
- ☐ fainting spells
- ☐ asthma
- ☐ sinus trouble
- ☐ frequent headaches
- ☐ tonsils & adenoids removed
- ☐ smoke/chew tobacco
- ☐ psychiatric care
- ☐ currently pregnant

Please describe any medical conditions checked above: ______________________________

____

Has your physician recommended pre-medication with antibiotics for routine dental visits? ☐ Yes ☐ No

Do you have any medical problems not listed above? ☐ Yes ☐ No

If yes, please describe: ____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand this information will be used by Matthew D. Jones, DDS to help determine appropriate and healthful orthodontic treatment. If there is any change in my medical status, I will inform the office of Matthew D. Jones, DDS.

I authorize my insurance company to pay to Matthew D. Jones, DDS all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize Matthew D. Jones, DDS to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: ______________________________________ Date: ______________________