smile solutions
Orthodontic Care for Children and Adults
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NJ SPEC #5238

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Tell Us About Yourself

Today's Date:________________

Name:____ Nickname:____________________________

Home Address:____

City:____________________________ State:_________________________ Zip Code:____________

Home Phone: (_____)__________ Birth Date: _____/_____/_____

General Dentist:_________________Whom may we thank for referring you?________________

Orthodontic Concerns:____

Responsible Party Information

Who will be responsible for your account? ☐Self ☐Spouse ☐Father ☐Mother ☐Other_____

Name:____

Address:____

Home Phone: (_____)__________ Work Phone: (_____)_________ Cell Phone: (_____)__________

Email: ____

Social Security #: _____________________ Birth Date: _____/_____/_____

Insurance Information

Insured's Name:__________________________________ Relation to Patient:__________________

Social Security/ I. D. #: _____________________ Birth Date: _____/_____/_____

Employer:____

Insurance Company:______________________ Group #:_____________ Phone: (_____)________

Do you have secondary insurance coverage? ☐ Yes ☐ No If yes:

Insured's Name:__________________________________ Relation to Patient:__________________

Social Security/I. D. #: _____________________ Birth Date: _____/_____/_____

Employer:____

Insurance Company:______________________ Group #:_____________ Phone: (_____)________

Insurance Company Address:____

Emergency Information

Name of nearest relative not living with you:____

Complete address:____

Home Phone:(______)_________ Work Phone:(______)_________

Medical History

1. Are you under the care of a physician? ☐ Yes ☐ No
   If yes, what condition? ____________________
2. Are you currently taking any medication? ☐ Yes ☐ No
   If yes, please list medications: ____________________
3. Do you have or have you had any of the following problems or diseases? (check if yes)
   ☐ Heart Murmur – If yes, do you take medication prior to dental appointments? ☐ Yes ☐ No
   ☐ Heart Problems
   ☐ Hepatitis, Jaundice or Liver Disease
   ☐ Asthma or Hay Fever
   ☐ Diabetes
   ☐ Aids
   ☐ Other____________________
4. Are you allergic to any drugs/medications (such as penicillin, codeine, aspirin) or have a latex allergy? ☐ Yes ☐ No
   If yes, what are you allergic to? ____________________
5. Do you have any disease, condition or other problems not listed that you think we should know about? ☐ Yes ☐ No
   If yes, describe: ____________________
6. Are you pregnant? ☐ Yes ☐ No

Dental History

1. Do you have any pending dental work? ☐ Yes ☐ No
   If yes, what? ____________________
2. When was your last dental check-up? ____________________
3. When was your last dental cleaning? ____________________
4. Have you ever had any abnormal bleeding associated with previous extractions, surgery or trauma? ☐ Yes ☐ No
5. Do your gums bleed? ☐ Yes ☐ No
6. Are you aware of grinding or clenching your teeth? ☐ Yes ☐ No
7. Have there been any injuries to face, mouth or teeth? ☐ Yes ☐ No
8. Do you have any speech problems? ☐ Yes ☐ No
9. Have you ever been told of any missing or extra permanent teeth? ☐ Yes ☐ No
10. Do you experience pain or clicking in your jaw, ear or facial muscles upon opening your mouth? ☐ Yes ☐ No
    Headaches? ☐ Yes ☐ No
    Please describe: ____________________

12. Why are you seeking an orthodontic consultation? ____________________

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