

Welcome

Lake Oswego Orthodontics



1 About Yourself

Today's Date _____ Nickname _____

Your Name _____

Date of Birth _____ M, ___ F

Hobbies/Sports _____

Home # _____

Phone # to Confirm Appointment _____

Contact Person to Confirm Appointment _____

Home Address _____

General Dentist _____

Phone _____ Last Visit Date _____

What are the main concerns for this orthodontic consultation?

2 Who May We Thank for Referring You?

___ Dentist, ___ Friend name _____, ___ Insurance

___ Internet Listing _____, ___ Mailing Brochure

___ Phone Book/Qwest, ___ Phone Book/Verizon

___ Sign in the Building

___ Other, please explain _____

3 Primary Responsible Party

Name _____ Relation _____

Billing Address _____

Home # _____ Work # _____

4 Primary Orthodontic Insurance

Insurance Co. Name _____

Phone # _____

Claim Address _____

Policy Owner's Name _____

Employer _____ Group # _____

ID or SSN _____ Date of Birth _____

Secondary Orthodontic Insurance

Insurance Co. Name _____

Phone # _____

Claim Address _____

Policy Owner's Name _____

Employer _____ Group # _____

ID or SSN _____ Date of Birth _____

By signing below, you agree to authorize the orthodontist to release any information from the diagnosis and records to any third party dental insurance group you belong to with the benefits payable to the orthodontist for treatment rendered within the office.

Signature _____ Date _____

5 Dental History

Please check if you had or currently have any of the follow conditions, and date it was diagnosed

- Teeth Grinding or Clenching
- Sore and or tender Jaws
- History of TMJ problems
- Gum disease
- Bleeding gums
- Fear of dental treatment
- Sore teeth
- Sensitive teeth
- Mouth breathing
- Mouth blistering or ulcers
- Finger or lip sucking
- Tongue thrusting habit
- Gag easily
- Bad Breath

Brush teeth daily __Y, __N Floss teeth daily __Y, __N

- Prior orthodontic treatment, explain _____
- Prior oral surgery, explain _____
- Other, explain _____

6 Current Medications

Physician _____

Phone _____

Please list all current medications and the medical conditions for its use _____

7 Medical History

Please check if you had or currently have any of the follow conditions, and date it was diagnosed

- High blood pressure
- Chest Pains
- Stroke
- Rheumatic Fever
- Shortness of Breath
- Heart Trouble or Murmur
- Prosthetic Device
- Need antibiotics before dental treatment __Y, __N
- Lung disease
- Asthma
- Allergy to Latex
- Other allergy or hay fever, explain _____
- Sinus Problem
- Ulcers or stomach problems
- Diabetes
- Hepatitis or liver disease
- Kidney disease
- Thyroid trouble
- Sexually transmitted disease
- Arthritis
- Cancer
- Bruise easily, prolonged bleeding
- Glaucoma
- Epilepsy
- Psychiatric therapy
- Exposed to HIV
- HIV or AIDS
- Possibly pregnant
- Take birth control pills
- Joint disease
- Other, explain _____
- None of the above**

8 I understand that the information that I have given is correct, and it is my responsibility to inform this office of any changes in my dental and medical status, and medications. I authorize the orthodontist and staff to perform the services for me.

Signature _____ Date _____

9 I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my orthodontic insurance does not cover.

Signature _____ Date _____