ORTHODONTICS OF WESTON
DR. MARISSA COOPER

Personal Information

Today's Date: _____

Name: _____

Title: Mr. Mrs. Ms. Miss Dr. Other_____

Birthdate:_____/_____/_____ Age_____ Sex_____

Address: _____
Apt/Condo#

_____
City State Zip

Home_____Cell_____Wk_____

Email:_____

Hobbies/Interests:_____

Employer: _____

Occupation _____

Spouse's Name:_____

Employer:_____

Occupation:._____

Business Phone: (_____)_____

General Dentist: _____

_____
City State

Date of Last Visit: _____

Whom may we thank for referring you?

_____

Name and Address of person responsible for account:

Name_____

Billing Address_____

_____
City State Zip

Phone: (_____) _____

Primary Orthodontic Insurance

Orthodontic Coverage? Yes____No____

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone :(_____)_____

Group # (Plan, Local, or Policy #):_____

Insured's Name: _____

Insured's Date of Birth:_____ID#_____

Relationship to Patient:_____

Insured's
Employer:_____

Secondary Orthodontic Insurance

Orthodontic Coverage? Yes____No____

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone :(_____)_____

Group # (Plan, Local, or Policy #):_____

Insured's Name: _____

Insured's Date of Birth:_____ID#_____

Relationship to Patient:_____

Insured's
Employer:_____

Dental History

Has patient ever had previous orthodontic treatment?_____
Has any other family member been treated in this office:____
Please name them:_____
Has patient ever been treated for gum disease?_____
Has the patient: (Please circle Y or N)

1. Had any injuries to the face, head or neck? Y N
2. Received a severe blow to the teeth or jaw? Y N
3. Had difficulty chewing or swallowing food? Y N
4. Had bleeding or infection of the gums? Y N
5. Have you ever sucked a finger? Y N
   (until what age_____)
6. Had permanent teeth removed? Y N
7. Experienced frequent headaches? Y N
8. Had pain in face, neck or shoulder region? Y N
9. Had pain or popping of the jaw joint (T.M.J.)? Y N
10. Had difficulty in opening or closing the jaw? Y N
11. Does the patient clench or grind the teeth? Y N
12. Do the jaws get tired during a meal? Y N
13. Had any unusual dental problems? Y N
14. Had any adverse reaction to latex? Y N
15. Had any adverse reaction to local anesthetics? Y N

You are interested in orthodontic treatment for:

____Improved Appearance
____Improved Function
____Relief and Comfort
____Improved Oral Health
____Improved speech
____Other, Explain:
_____

How did you first become aware of your need for orthodontic treatment?_____
How did you select our office?_____
Have you ever had an orthodontic consultation or treatment before now?_____

Medical History

Name of Patient's Physician:_____

_____
City State

(Please circle Y or N)
Are you currently under the care of a physician? Y N
If yes, please explain:_____
Are you presently taking any medications? Y N
If yes, please list_____
List any medications, food, pollens, or other elements you may be allergic to:_____
Are you currently pregnant? Y N
Is there anything else that the doctor should know about your health?_____

Do you take antibiotic pre-medication before any dental procedures?_____
Do you chew or smoke tobacco? Vape?_____
Have you noticed any changes in your face or jaws?___

Have you ever experienced any of the following medical problems?

Please circle:

Adenoids Removed	High or Low BP
AIDS/HIV	History of Bulimia or Anorexia
Anemia	Infectious Disease
Arthritis	Intestinal Disorder
Asthma	Kidney Stones
Canker Sores	Nervous Disorders
Diabetes	Osteoporosis
Drug/Alcohol Dependency	Prolonged Bleeding
	Rheumatic Fever
Epilepsy/seizures	Sleep Apnea
Frequent Colds	Snoring
Heart Disease	Speech/Hearing Problem
Heart Murmur (MVP)	Thyroid Problems
Hepatitis	Tonsils Removed
Herpes	Tuberculosis

I understand that the information which I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform the office of any changes in my medical status. I also authorize the dental staff to perform the necessary dental services that I may need.

_____
Signature of Patient Date