TEEM ORTHODONTICS PLLC
SHOW YOUR SMILE

Patient Information

Today's Date: _____

Name: _____
Last First Middle Initial

Birth Date: _____ / _____ / ____ **Age**: _____

☐ **Male** ☐ **Female**

☐ **Single** ☐ **Married** ☐ **Divorced**

General Dentist: _____
Phone: _____
Date of last appointment: _____

☐ **Self (if over 18 yrs)** ☐ **Mother** ☐ **Father** ☐ **Other**

Name: _____
Home Address:_____
_____
City **State** **Zip**
Home Phone: _____
Cell/Work Phone: _____
Email: _____
Occupation: _____
Employer: _____
SS# (if over 18 yrs):_____
Other family members seen by us?
_____
_____
Who may we thank for referring you to our office?
_____

☐ **Mother** ☐ **Father** ☐ **Other**

Name: _____
Home Address: _____
_____
City **State** **Zip**
Home Phone: _____
Cell/Work Phone: _____
Occupation: _____
Employer: _____
SS# (if over 18 yrs): _____

Insurance Information

Orthodontic Coverage: ☐ **Yes** ☐ **No** ☐ **Unsure**
Insurance Company: _____
Insurance Co. Phone #: _____
Policy Holder's Name: _____
Policy Holder's Birth Date: _____ / _____ / _____
Policy Holder's ID# or SS#: _____
Group # _____
Policy Holder's Relationship to Patient: _____

Secondary Insurance (if applicable)

Orthodontic Coverage: ☐ **Yes** ☐ **No** ☐ **Unsure**
Insurance Company: _____
Insurance Co. Phone #: _____
Policy Holder's Name: _____
Policy Holder's Birth Date: _____ / _____ / _____
Policy Holder's ID# or SS#: _____
Group # _____
Policy Holder's Relationship to Patient: _____

Medical History

Are you under a Physician's care: ☐ **Yes** ☐ **No**
Physician's Name_____
Phone: _____ **Date of last visit:**_____

Are you taking any prescription or over the counter Medications on a regular basis? ☐ **Yes** ☐ **No**
Please list all medications:
_____
_____
_____

Has the patient ever been evaluated or had orthodontic treatment before? ☐ **Yes** ☐ **No**

Has the patient been informed of any missing or extra permanent teeth? ☐ **Yes** ☐ **No**

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Please circle Y (Yes) or N (No) for ALL the questions below as pertaining to the patient:

Is the patient allergic to?

Y	N	Latex
Y	N	Metals/Nickel
Y	N	Plastics

Has the patient ever had any of the following medical problems?

Y	N	Abnormal Bleeding
Y	N	Anemia
Y	N	Artificial Bones/Joints/Valves
Y	N	Asthma/Arthritis
Y	N	Blood Transfusion
Y	N	Cancer/ Chemotherapy
Y	N	Congenital Heart Defect
Y	N	Diabetes
Y	N	Difficulty Breathing
Y	N	Emphysema
Y	N	Epilepsy/ Seizures/ Fainting
Y	N	Fever Blisters/Herpes
Y	N	Heart Attack/Stroke
Y	N	Heart Murmur
Y	N	Heart Surgery/pacemaker
Y	N	Hepatitis
Y	N	High/ Low Blood Pressure
Y	N	HIV/AIDS
Y	N	Mitral Valve Problems
Y	N	Psychiatric Problems

Are there any additional medical conditions or allergies we should be informed of?

_____

_____

_____

What is your chief concern:_____

_____

_____

_____

For Female Patients

Are you pregnant? ☐ **Yes** ☐ **No**

If yes, how many weeks? _____

Are you nursing? ☐ **Yes** ☐ **No**

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

I authorize TEEM ORTHODONTICS PLLC staff to perform all necessary orthodontic/dental services.

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____

Signature of Parent/Guardian or Patient (if over 18 yrs)

_____

Date

Emergency Contact Person:

Name: _____

Phone: _____

Relationship to patient: _____

OFFICE USE ONLY

I reviewed the medical/dental information above with the patent/guardian and the patient named herein.

Initials _____

Date _____