RUSTY JONES ORTHODONTICS

Date:_____

PATIENT INFORMATION

Patient's Last Name_____ First Name_____ DOB_____ Age_____
Name you would like to go by_____
Patient's Home Address_____ City_____ State_____ Zip_____
Patient's Home Phone Number_____
E-Mail (used for appointment reminders, kept confidential)_____
Driver's license number_____
Who may we thank for referring you to our office? _____
Is the patient Single Married Divorced Widowed
In Emergency Notify_____
Name Address City State Zip Phone

PERSON RESPONSIBLE FOR THIS ACCOUNT

Name_____DOB_____
Address_____ City_____ State_____ Zip_____
SS#_____ Daytime Phone _____ Email _____
Cell Phone#_____ Relationship to Patient_____

INSURANCE INFORMATION

Primary Insurance Information

Insured's Name_____ Insured's DOB_____Insured's SS#_____ Insured ID#_____
Employer's Name_____ Employer's Phone #_____
Employer's Address_____City_____State_____Zip_____
Insurance Company_____ City_____ State_____ Zip_____
Insurance Phone#_____ Name of Dental Plan_____

Secondary Insurance Information

Insured's Name_____ Insured's DOB_____Insured's SS#_____ Insured ID_____
Employer's Name_____ Employer's Phone#_____
Employer's Address_____ City_____ State_____ Zip_____
Insurance Company_____ City_____ State_____ Zip_____
Insurance Phone#_____ Name of Dental Plan_____

DENTAL HISTORY

Dentist_____ Date of Last Visit_____
Dentist's Address_____City_____State_____Zip_____
Phone#_____ What concerns you most about your teeth?_____
Does the patient want teeth straightened?_____
YES NO Have there ever been any injuries to the face, mouth, or teeth?_____
YES No Have you ever been informed of missing, extra or chipped teeth?_____
YES No Have you ever had any abscessed teeth?_____
YES No Is any of your mouth sensitive to temperature or pressure?_____
Yes No Do your gums bleed when you brush your teeth?_____
Yes No Do you have any type of thumb or tongue habit?_____
YES NO Have you ever had any speech therapy?_____

YES NO Do you have TMJ?_____
YES NO Are you aware of your jaw clicking or popping?_____
YES NO Have you ever been told that you grind your teeth?_____
YES NO Are you aware of clenching your teeth?_____
YES NO Do you have "Tension" headaches?_____
YES NO Do you have "Frequent" headaches?_____
YES NO Do you brush your teeth daily? How many times?_____
YES NO Do you floss your teeth daily?_____
Who first noticed a possible orthodontic problem?_____
Chief Concern for evaluation and information desired:_____
Have x-rays been taken recently?_____ When_____

Medical History

Reviewed with patient by_____ Date_____
Physician _____Date of last visit_____
Physician's Address_____ City_____ AZ_____ Zip_____

Please Circle Yes or No (If Yes, please fill in the details)

Yes No Are you taking any medications?_____
Yes No Are you allergic to any medication?_____
Yes No Are you presently under care of a physician_____
Yes No Have you ever had any major operation?_____
Yes No Have you had your tonsils or adenoids removed?_____
Yes No Have you had any of the following: Asthma___ Allergies___Hayfever___Throat Infections_____
Yes No Are you allergic to anything? If yes please describe_____

Please circle the appropriate answer for the medical conditions below:

Yes	No	Abnormal Bleeding	Yes	No	Endocrine Problems	Yes	No	Epilepsy
Yes	No	Tuberculosis	Yes	No	Anemia	Yes	No	Arthritis
Yes	No	Lung/Respiratory	Yes	No	Thyroid Disease	Yes	No	HIV+
Yes	No	Heart Murmur	Yes	No	Nervous Disorders	Yes	No	Herpes
Yes	No	Arthritis	Yes	No	Blood Disorder	Yes	No	Sinusitis
Yes	No	Heart Problems	Yes	No	Bone/Joint Disorders	Yes	No	Cancer
Yes	No	Pneumonia	Yes	No	Prolonged Bleeding	Yes	No	Fainting
Yes	No	Diabetes	Yes	No	Nervous Disorders	Yes	No	Hyperactive
Yes	No	Kidney Involvement	Yes	No	High Blood Pressure	Yes	No	AIDS
Yes	No	Rheumatic Heart	Yes	No	Hepatitis Type _____	Yes	No	Emotional Problems

For Women Only: Are you pregnant? _____ Other: _____
Remarks: _____

BENEFITS OF ORTHODONTICS

Aesthetics, Health and Function

Orthodontics is a service that provides an improvement in the appearance of the teeth and in the general function of the teeth, and general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout lifetime, and there can be some movement of the teeth, and some change after treatment. I hereby state that I have read and understand the above paragraph, and that I have truthfully to the best of my ability answered all the above questions.

Patient/Parent Signature_____Date_____

OFFICE USE

I Verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.
Initials_____ Date : _____