Jupiter Orthodontics

ABOUT THE PATIENT

● Mr. ● Mrs. ● Ms. ● Dr.

Name: _____
First Middle Last

I prefer to be called: _____ ● Male ● Female

Birth Date: ___/___/___ Age: _____ Social Security #: ___-___-___

Address: _____

_____
City State Zip

How long at current address? _____

Email: _____ @ _____

Home# (___) _____ Cell# (___) _____

PERSON RESPONSIBLE FOR ACCOUNT

● Mr. ● Mrs. ● Ms ● Dr.

Name: _____
First Middle Last

Relation to Patient: _____ ● Male ● Female

Birth Date: ___/___/___ Age: _____ Social Security # ___-___-___

● Single ● Married ● Divorced ● Widowed ● Separated

Address: _____ ● Same as above
City State Zip

Email: _____ @ _____

Home#: (___) _____ Cell#: (___) _____

Employer: _____

Work#: (___) _____ Number of years with current employer? _____

What is the method for us to contact you? ● Cell ● Home ● Work ● Email

SPOUSE INFORMATION

His / Her Name: _____
First Middle Last

Birth Date: ___/___/___ Age: _____ Social Security#: ___-___-___

Employer: _____

Home#: (___) _____ Cell#: (___) _____

Work#: (___) _____

By signing below, patient / responsible party acknowledges the information filled out on this form is accurate and agrees to notify Jupiter Orthodontics of any changes that may occur.
In order to establish a payment plan for you, it will be necessary for us to run a credit report.
●Yes ● No

Signature: _____ **Date:** _____

Today's Date: _____

Please fill out this form completely. The better we communicate, the better we can care for you.

DENTAL INFORMATION

General Dentist:

_____

Date of last dental check up?

_____

Whom may we thank for referring you?

_____

Other family members seen by us:

_____

Primary care physician:

_____

ORTHODONTIC INSURANCE

Orthodontic Coverage?
● Yes ● No

Policy Holder's Name:

_____

Policy Holder's Birthdate:

_____

Policy Holder's Social Security #:

_____

Employer:

_____

Name of Insurance Company:

_____

Insurance Company Phone #:

_____

Policy #:

_____

MEDICAL HISTORY

Have you ever had any of the following diseases or medical problems:

Abnormal Bleeding	Yes	No
Heart Problems / Murmur / Pacemaker	Yes	No
ADD / ADHD	Yes	No
Hemophilia	Yes	No
Any Hospital Stays	Yes	No
High / Low Blood Pressure	Yes	No
Any Operations	Yes	No
Hearing Impairment	Yes	No
Anemia	Yes	No
Hepatitis	Yes	No
Artificial Bones / Joints / Valves	Yes	No
HIV / AIDS	Yes	No
Asthma / Arthritis	Yes	No
Kidney / Liver Problems	Yes	No
Blood Transfusion	Yes	No
Lupus	Yes	No
Cancer / Chemotherapy	Yes	No
Mitral Valve Prolapse	Yes	No
Chicken Pox	Yes	No
Mumps	Yes	No
Congenital Heart Defect	Yes	No
Measles	Yes	No
Convulsions / Epilepsy / Seizures	Yes	No
Psychiatric Problems	Yes	No
Diabetes	Yes	No
Diphtheria	Yes	No
Polio	Yes	No
Radiation Treatment	Yes	No
Difficulty Breathing	Yes	No
Rheumatic / Scarlet Fever	Yes	No
Drug / Alcohol Abuse	Yes	No
Sinus Problems	Yes	No
Emphysema	Yes	No
Severe /Frequent Headaches	Yes	No
Endocrines	Yes	No
Shingles	Yes	No
Fever Blisters / Herpes	Yes	No
Sickle Cell Disease / Traits	Yes	No
Glaucoma	Yes	No
Tuberculosis (TB)	Yes	No
Handicaps / Disabilities	Yes	No
Ulcers / Colitis	Yes	No
Heart Attack / Stroke	Yes	No
Venereal Disease	Yes	No

Please list any serious medical condition(s) that you have ever had:

_____

FOR WOMEN:

Has menstruation Begun?	Yes	No
Are you using prescribed birth control?	Yes	No
Are you pregnant or nursing?	Yes	No

Please list any allergies:

_____

Do you require pre-medication before any dental procedures? Yes No

Have you ever experienced any of the following?

Clenching / Grinding	Yes	No
Nursing Bottle Habits	Yes	No
Lip Sucking / Biting	Yes	No
Speech Problems	Yes	No
Mouth Breather	Yes	No
Thumb / Finger Sucking	Yes	No
Nail Biting	Yes	No
Tongue Thrust	Yes	No

DENTAL HISTORY

What are the main concerns that you would like orthodontics to accomplish?

_____

_____

_____

Have you been evaluated for orthodontic treatment	Yes	No
Has puberty begun?	Yes	No
Had a serious / difficult problem associated with any previous dental work?	Yes	No
Do you now, or have you ever experienced pain / discomfort in your jaw joint (TMJ/TMD)?	Yes	No
Had any injuries to the face, mouth, teeth or chin?	Yes	No
Ever taken Fen-Phen (Redux, Pondimin)?	Yes	No
Ever taken Fosamax, or any other bisphosphonate?	Yes	No
Do you have any missing or extra permanent teeth?	Yes	No
Do you smoke or use tobacco in any form?	Yes	No
Gums ever bleed?	Yes	No
Do you see a general dentist regularly?	Yes	No
Do you like your smile?	Yes	No
Had tonsils or adenoids removed?	Yes	No
Do you brush your teeth daily?	Yes	No
Floss daily?	Yes	No
Are you aware that some appointments may / will infringe upon work or school time?	Yes	No