DR. Heather Brown Orthodontics
The Secret Behind a Beautiful Smile...

Today's date _____/_____/_____

NEW PATIENT

We would like to welcome you to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. Thank you for your cooperation.

PATIENT INFORMATION - ADULT

○ MALE ○ FEMALE

Patient's Name _____ Age_____ Birth Date ____/____/_____
FIRST | MIDDLE | LAST — MM DD YYYY

Nickname (if preferred) _____ Email @_____

Home phone _____ Cell Phone _____ SS # _____/_____/_____

Home address _____ City/State/Zip _____ , _____ , _____
STREET

Employer _____ Employer's Address _____

Occupation _____ How Long? _____

General Dentist _____ Who referred you to our office? _____

Have we treated another member of your family? ○ YES ○ NO. If Yes, Who? _____

What are the main concerns you have about your teeth?_____

Have you visited an orthodontist before ○ YES ○ NO. If Yes, did you begin treatment?_____

INSURANCE INFORMATION

Marital Status ○ Single ○ Married ○ Widowed ○ Divorced ○ Separated ○ Domestic Partner

PRIMARY

Insurance Company Name _____ Insurance Company Phone _____

Insurance Company Address _____ Group or Plan _____

Insured's Name _____ Insured's Birthday _____

Relationship _____ Insured's SS # _____/_____/_____

Insured's Employer _____ Employer's Address _____

SECONDARY

Insurance Company Name _____ Insurance Company Phone _____

Insurance Company Address _____ Group or Plan _____

Insured's Name _____ Insured's Birthday _____

Relationship _____ Insured's SS # _____/_____/_____

Insured's Employer _____ Employer's Address _____

DENTAL AND MEDICAL HISTORY

Are you under the care of a physician? ◯ YES ◯ NO. If YES, for what reason? _____

Physician _____ Phone # _____

History of major illness? ◯ YES ◯ NO. If YES, Please describe _____

Any sensitivities or allergies? ◯ YES ◯ NO. If YES, please list _____

Currently taking any medications? ◯ YES ◯ NO. If YES, please list _____ Reason_____

Have you been treated for any of the following?

◯ Autism ◯ ADHD ◯ Depression ◯ Diabetes ◯ Herpes ◯ Heart Condition ◯ Cancer

◯ Asthma ◯ HIV/AIDS ◯ Hepatitis ◯ Epilepsy ◯ High Blood Pressure ◯ Tuberculosis ◯ Other _____

Do you require antibiotics before dental treatment? ◯ YES ◯ NO. If YES, Please explain _____

Have there been any injuries to your face, mouth or chin? ◯ YES ◯ NO.

Have you ever had pain/tenderness in you jaw joint? (TMJ/TMD) ◯ YES ◯ NO. Are you pregnant? ◯ YES ◯ NO.

Do/Did you have any of the following habits?

◯ Grinding Teeth ◯ Finger/thumb sucking ◯ Tongue Thrusting

◯ Chronic Mouth Breathing ◯ Speech Problems ◯ Chewing/ Eating Problems

Is there anything else about your medical history that we should be aware of? _____

SIGNATURE

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

I hereby authorize release of any information related to insurance claim. I consent to examination by the doctor and I authorize payment of any insurance benefits to the office.

SIGNATURE _____ DATE _____/_____/_____

OFFICE USE ONLY - OFFICE USE ONLY - OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.
Initials: _____ Date _____/_____/_____

Doctor's comments: _____

_____

_____

Medical History Update:

1. Date _____/_____/_____ Signature: _____

Comments: _____

2. Date _____/_____/_____ Signature: _____

Comments: _____