Welcome to ROTH ORTHODONTICS

PATIENT INFORMATION AND HEALTH HISTORY

PERSONAL INFORMATION

Date:

Name _____ _____ Male ☐ Female ☐
Last First MI Preferred Name

Birthdate _____ Age _____ SSN _____ Driver's License # _____

Address _____
Street City State ZIP Code

Cell Phone ( ) _____ Other Phone ( ) _____ ☐ Home ☐ Other: _____

Employer _____ Occupation _____ How Long? _____

Employer Address _____
Street City State ZIP Code

Employer Phone ( ) _____ Where and when are best times to reach you? _____

Dentist's Name _____ Who may we thank for referring you? _____

Other family members seen by us:

SPOUSE INFORMATION

Name _____ Cell Phone ( ) _____
Last First MI

Employer _____ Occupation _____ Work Phone ( ) _____

Birthdate SSN

DENTAL INSURANCE INFORMATION

Primary Insurance Co. Name _____ Orthodontic Coverage? Yes ☐ No ☐

Insurance Co. Address _____
Street City State ZIP Code

Insurance Phone ( ) _____ Group # (Plan, Local or Policy #) _____

Insured's Name _____ Relationship _____
Last First MI

Insured's Birthdate _____ Insured's SSN _____

Insured's Employer/Address _____
Employer Name Street City State ZIP Code

Secondary Insurance Co. Name _____ Orthodontic Coverage? Yes ☐ No ☐

Insurance Co. Address _____
Street City State ZIP Code

Insurance Phone ( ) _____ Group # (Plan, Local or Policy #) _____

Insured's Name _____ Relationship _____
Last First MI

Insured's Birthdate _____ Insured's SSN _____

Insured's Employer/Address _____
Employer Name Street City State ZIP Code

AUTHORIZATION

This office reserves the right to verify the credit status of potential patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. If Roth Orthodontics accepts the insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payments and deductibles that my insurance does not cover. I hereby authorize the Roth Orthodontics to release all information necessary to secure the payment of benefits, and I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature: Date:

Patient Name: _____

Medical History

Physician's Name _____

Phone # _____ Date of last visit _____

Your current physical health is: ◯ **Good** ◯ **Fair** ◯ **Poor**

	Yes	No
Are you currently under the care of a physician?	◯	◯
Please explain:_____		
Do you smoke or use tobacco in any form?	◯	◯
Have you had any metal rods, pins or implants?	◯	◯
Are you taking any prescription/over-the-counter drugs?	◯	◯
Please list:_____		
Have you ever taken Phen-fen?	◯	◯
If so, when? _____		
For Women:		
Are you taking birth control pills?	◯	◯
Are you nursing?	◯	◯
Are you pregnant? If yes, week #_____	◯	◯

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

Y	N		Y	N	
☐	☐	Abnormal bleeding	☐	☐	Hepatitis
☐	☐	AIDS	☐	☐	Herpes/Fever Blisters
☐	☐	Alcohol/Drug abuse	☐	☐	High blood pressure
☐	☐	Anemia	☐	☐	HIV
☐	☐	Arthritis	☐	☐	Hospitalized for any reason
☐	☐	Joint replacement	☐	☐	Kidney problems
☐	☐	Artificial heart valves	☐	☐	Liver disease
☐	☐	Asthma	☐	☐	Low blood pressure
☐	☐	Blood transfusion	☐	☐	Mitral valve prolapse
☐	☐	Cancer/Chemotherapy	☐	☐	Pacemaker
☐	☐	Colitis	☐	☐	Psychiatric problems
☐	☐	Congenital heart defect	☐	☐	Radiation treatment
☐	☐	Diabetes	☐	☐	Rheumatic/Scarlet Fever
☐	☐	Difficulty breathing	☐	☐	Seizures
☐	☐	Emphysema	☐	☐	Shingles
☐	☐	Epilepsy	☐	☐	Sickle Cell Disease/Trait
☐	☐	Fainting spells	☐	☐	Sinus problems
☐	☐	Frequent headaches	☐	☐	Stroke
☐	☐	Glaucoma	☐	☐	Thyroid problems
☐	☐	Hay fever	☐	☐	Tuberculosis (TB)
☐	☐	Heart attack/Surgery	☐	☐	Ulcers
☐	☐	Heart murmur	☐	☐	Venereal disease
☐	☐	Hemophilia			

Please list any other medical conditions not listed above:

Are you allergic to any of the following?

Y	N		Y	N	
☐	☐	Aspirin	☐	☐	Latex
☐	☐	Amoxicillin	☐	☐	Penicillin
☐	☐	Sulfa Drugs	☐	☐	Tetracycline
☐	☐	Erythromycin	☐	☐	Jewelry / Metal

Other drugs/materials you are allergic to:_____

Dental History

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

_____

_____

	Y	N
Have you ever had or been evaluated for orthodontic treatment?	☐	☐
Have you ever had a serious/difficult problem associated with any previous dental work?	☐	☐
Do you now or have you ever experienced pain/discomfort in your jaw joint (TMD/TMJ)?	☐	☐
Your current dental health is: Good ☐ Fair ☐ Poor ☐		
Do you still have your wisdom teeth?	☐	☐
Have you ever had an injury to your mouth/face?	☐	☐
Do you have any speech problems?	☐	☐
Do you generally breathe through your mouth:		
while awake?	☐	☐
while asleep?	☐	☐
Do you have any missing permanent teeth?	☐	☐
Do you have any extra permanent teeth?	☐	☐
Are you happy with the way your smile looks?	☐	☐

If no, what would you change?_____

_____

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

Signature:_____

Date: _____

OFFICE USE ONLY

I verbally reviewed the medical/dental information with the patient named herein.

Initials:_____ Date:_____

Additional reviews

Initials:_____ Date:_____

Initials:_____ Date:_____