Lufkin
714 Largent Street
Lufkin, Texas 75904
936.639.1397
Fax: 936.634.9791

Crockett
1050 E. Loop 304, Ste. 120
Crockett, Texas 75835
936.544.2855

Nacogdoches
808 N. University Dr.
Nacogdoches, Texas 75961
936.564.1218
Fax: 936.564.3371

Center
514 Tenaha
Center, Texas 75935
936.564.1218

Please complete this form in its entirety. The better we communicate, the better we can care for you.

① ABOUT YOU

Today's Date: ________E-Mail Address____________________

Name:____
Last First MI MR MRS MS DR

I prefer to be called:__________________ ❑ Male ❑ Female

Birthdate:___/___/___ Age:_______ SS#:___________________

Home Address:______________________________________
APT/CONDO #:

____
CITY STATE ZIP

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Hm #: (_____)___________Pager / Cell #:_________________

Wk #: (_____)_______________ Ext: _____________________

List children with age:_________________________________

____

Employer:____

Occupation:____

Where & When are best times to reach you?________________

Whom may we Thank for referring you?___________________

Other family members seen by us:_______________________

General Dentist:______________________________________

Last Visit Date:_______________________________________

② SPOUSE INFORMATION

His / Her Name:_______________________________________

Employer:____

Wk #: (___)_____________Ext: ________ SS #:___________

Birthdate: ___/____/____

Person Responsible for Account: _______________________

Wk #: (____)________Ext:___Hm #: (___)_______________

Billing Address:_______________________________________

Relation:_________________________SS #:______________

Employer: ____

③ ORTHODONTIC INSURANCE

Primary

Orthodontic Coverage: ❑ Yes ❑ No Dental Coverage: ❑ Yes ❑ No

Insurance Co. Name:____________________________________

Insurance Co. Address:__________________________________

Insurance Co. Phone #: (____)____________________________

Group # (Plan, Local or Policy #): ________________________

Insured's Name: _________________ Relation:______________

Insured's Birthdate: ____/____/____ Insured's SS #:___________

Insured's Employer: ____________________________________

Secondary

Orthodontic Coverage: ❑ Yes ❑ No Dental Coverage: ❑ Yes ❑ No

Insurance Co. Name:____________________________________

Insurance Co. Address:__________________________________

Insurance Co. Phone #: (____)____________________________

Group # (Plan, Local or Policy #): ________________________

Insured's Name: _________________ Relation:______________

Insured's Birthdate: ____/____/____ Insured's SS #:___________

Insured's Employer: ____________________________________

④ MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: ____________________________________

Phone #: (___)_______________Date of last visit: __________

CONTINUED ON BACK

MEDICAL HISTORY *continued*

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: ____________________

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

Have you had any metal rods, pins or implants? ❑ Yes ❑ No

Are you taking any prescription / over-the-counter drugs? ❑ Yes ❑ No

Please list each one: ____________________

Have you ever taken bisphosphonates for osteoporosis? ❑ Yes ❑ No

If so, when? ____________________

For Women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant: ❑ Yes ❑ No Week #: ________

Are you nursing? ❑ Yes ❑ No

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

Y N Abnormal Bleeding	Y N Hemophilia
Y N Anemia	Y N Hepatitis
Y N Artificial Bones / Joints / Valves	Y N High / Low Blood Pressure
Y N Asthma / Arthritis	Y N HIV+ / AIDS
Y N Blood Transfusion	Y N Hospitalized for Any Reason
Y N Cancer / Chemotherapy	Y N Kidney Problems
Y N Congenital Heart Defect	Y N Mitral Valve Prolapse
Y N Diabetes	Y N Psychiatric Problems
Y N Difficulty Breathing	Y N Radiation Treatment
Y N Drug / Alcohol Abuse	Y N Rheumatic /Scarlet Fever
Y N Emphysema	Y N Severe / Frequent Headaches
Y N Epilepsy / Seizures / Fainting	Y N Shingles
Y N Fever Blisters / Herpes	Y N Sickle Cell Disease / Traits
Y N Glaucoma	Y N Sinus Problems
Y N Heart Attack / Stroke	Y N Tuberculosis (TB)
Y N Heart Murmur	Y N Ulcers / Colitis
Y N Heart Surgery / Pacemaker	Y N Venereal Disease

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

Are you allergic to any of the following?

Y N Aspirin	Y N Dental Anesthetics	Y N Penicillin
Y N Any Metals/Plastics	Y N Erythromycin	Y N Tetracycline
Y N Codeine	Y N Latex	Y N Other

Please list any other drugs / materials that you are allergic to: ____________________

____

DENTAL HISTORY

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

____

____

Have you ever had or been evaluated for orthodontic treatment? ❑ Yes ❑No

Have you ever 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

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Do you still have wisdom teeth? ❑ Yes ❑ No

Have you ever had an injury to your: Mouth Teeth Chin (Please Circle)

Do you have any speech problems? ____________________

Do you generally breathe through your mouth? ❑ Yes ❑ No

If yes, please circle: While Awake? While Asleep?

Do you have any missing or extra permanent teeth? ❑ Yes ❑ No

Are you happy with the way your smile looks? ❑ Yes ❑ No

If not, 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. This office reserves the right to verify the credit status of potential patients and / or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

____

Signature Date

If this office accepts insurance, 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. 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.

____

Signature Date

THANK YOU FOR COMPLETING THIS FORM IN ITS ENTIRETY!

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials:________ Date:______

Doctor's Comments: ____________________

____

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