

Commonwealth Orthodontics

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Specialist in Orthodontics and Dentofacial Orthopedics

CONFIDENTIAL PATIENT INFORMATION

Date: _____

Patient Name: _____

Address: _____

City, State, Zip: _____

Phone: (Preferred) _____ (Secondary) _____

Date of Birth: _____ Age: _____ SSN: _____ - _____ - _____

Email: _____

Occupation: _____ Employer: _____

Dentist Name: _____

Who may we thank for referring you to our office? _____

Is this your first visit to an Orthodontist? Yes / No

Please describe your orthodontic concerns: _____

PRIMARY DENTAL INSURANCE - *ALL fields are required for this section*

Insurance Company: _____ Insurance Phone Number: _____

Policy Number: _____ Group Number: _____

Policy Holder's Name: _____ SSN: _____ - _____ - _____ DOB: _____

Relationship to patient: _____

Policy Holder Address (if different than above): _____

Occupation: _____ Employer: _____

Employer Address: _____

MEDICAL AND DENTAL HISTORY

Have you ever worn orthodontic appliances before? Yes/No

Are you under the care of a physician? Yes/No

If yes, why? _____

Are you taking any medications? Yes/No

If yes, type and dose: _____

Are you allergic to any medications, latex or nickel? Yes/No

If yes, which? _____

Do you have or have you ever had:

Injury to the teeth or jaws? Yes/No

Liver disease, hepatitis, or diabetes, Yes/No

Epilepsy or other seizures? Yes/No

Heart disease, murmur, or rheumatic fever? Yes/No

Asthma or other breathing problems? Yes/No

Immunosuppressant disorders? Yes/No

Bleeding problems? Yes/No

Problems with the temporomandibular joint? Yes/No

Are you pregnant? Yes/No/NA

If you answered yes to any of the above, or have any other conditions we should be aware of, please describe them here:

PLEASE INFORM US IMMEDIATELY OF ANY CHANGE IN YOUR MEDICAL/DENTAL STATUS. THANK YOU.