WELCOME

TO THE ORTHODONTIST

Stuart A. Sheer, D.D.S.
Specialist in Orthodontics
for Children and Adults

1 About You

Email Address: ____________________

Name: ____________________
LAST FIRST MI MR MRS MS DR

I prefer to be called: ____________ ☐ Male ☐ Female

Birthdate: ________ Age: ______ SS #: ________

Home Address: ____________________

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home #: ________ Cell #: ________

Work #: ________ Other #: ________

Employer: ____________________

Employer Address: ____________________

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: ____________________

Work #: ________ Ext: ______ SS #: ________

Cell #: ________ Birthdate: ________

3 Person Responsible for Account

Name: ____________________

Work #: ________ Ext: ______ Home #: ________

Billing Address: ____________________

Relation: ________ SS #: ________

Employer: ________ DL#: ________

4 Financial Responsibility

Primary Orthodontic Insurance

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 ID #: ________

Insured's Employer: ____________________

Secondary Orthodontic Insurance

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 ID #: ________

Insured's Employer: ____________________

5 Emergency Contact

In the event of an emergency, is there someone who lives near you that we should contact?

His/Her Name: ____________________

Relation: ________ Work #: ________

Home #: ________ Cell #: ________

6 Medical History (continued on next page)

Do you have a personal physician: ☐ Yes ☐ No

Physician's Name: ____________________

Phone #: ____________________

Date of Last Visit: ____________________

6 Medical History (continued)

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

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

If yes, please explain: ____________________

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

Please list each one: ____________________

For Women: Are you using a prescribed method of birth control? ☐ 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: ____________

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7 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 like you smile? ☐ Yes ☐ No Gums ever bleed? ☐ Yes ☐ No

Have you ever had an injury to your (please circle): Mouth Teeth Chin

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

Have you ever taken Fosamax or any other bisphosphonate? ☐ Yes ☐ No

8 Agreement to Dental Services

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 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 ____________

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

9 Thank you for filling out this for completely.

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. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office.

Signature ____________________ Date ____________

OFFICE USE ONLY 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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