

Ted Vossers, DDS, MS, PA

Orthodontic Patient Information

Date ___/___/___
Update ___/___/___

-Please Print-

Date of Birth ___/___/___

Patient Name _____ Sex _____ SS# _____

Home Address _____ Preferred Name _____

Home Phone _____

Email Address _____ Cell Phone _____

Occupation/School _____ Employer/Grade _____ WorkPhone _____

Emergency Contact _____ Relationship _____ Phone _____

Hobbies/ Interests _____

Whom may we thank for recommending our office to you? _____

Physician _____ Family Dentist _____ Last Dental Visit _____

Please list any family members treated here _____

Person responsible for payment of the account _____ Relationship _____

SS# _____ D.O.B. _____

Orthodontic Insurance _____ Company Name _____

Marital Status(circle one): Single Married Separated Divorced Widowed Other _____

If applicable: Spouse's Name _____ SS# _____

Occupation _____ Employer _____ Business Phone _____

Names & ages of children _____

MEDICAL HISTORY

Yes No Any major or unusual illnesses?

Explain _____

Yes No Currently under physician's care?

Reason _____

Yes No Have taken or are taking Bisphosphonates(ex: Fosomax)?

How long ago? _____

Yes No Currently taking medication?

List _____

Yes No Any drug allergies/sensitivities?

List _____

Yes No PreMed-Dental Work Yes No Osteoporosis Yes No Joint Replacement

Yes No Heart Murmur Yes No Hepatitis/Liver Disease Yes No Speech/ Hearing Problems

Yes No Rheumatic Fever Yes No Heart Trouble Yes No Allergies

Yes No Epilepsy Yes No High Blood Pressure Yes No Diabetes

Yes No Fainting/Dizziness Yes No Cold Sores/ Herpes Yes No Frequent Colds/Flu

Yes No Asthma Yes No AIDS Antibody Positive Yes No Tonsillitis/ Adenitis

Yes No Glaucoma Yes No Abnormal Bleeding Yes No Tonsils/ Adenoids Removed

Yes No Contact Lenses Yes No Frequent Headaches Yes No Tuberculosis

Please turn over to back of page

DENTAL HISTORY

Yes No Any injuries to the face, mouth, or teeth?

Explain _____

Yes No Has the patient ever sucked a thumb or finger? Until what age? _____

Yes No Any history of jaw joint soreness, clicking, or popping? _____

Yes No Any history of clenching or grinding of teeth? _____

Yes No Has an orthodontist been consulted previously? When? _____

Yes No Has the patient had any previous orthodontic treatment? When? _____

Why are you seeking orthodontic consultation? (What is your main concern?) _____

Any additional information which you feel would help make your association with us more enjoyable.

RELEASE

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper orthodontic care.

I authorize release of any information concerning my (or my child's) orthodontic care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) orthodontic care, advice and treatment to my dentist and/or referred specialist.

I hereby authorize payment of insurance benefits directly to Ted Vossers, DDS, MS, PA otherwise payable to me.

I understand that my orthodontic care insurance carrier or payor of my orthodontic benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts.

Patient's or Guardian's

Signature _____ Date _____

Witness Signature _____ Date _____