WELCOME TO OUR PRACTICE

THE BENEFITS OF A HAPPY, HEALTHY SMILE ARE IMMEASURABLE! A BEAUTIFUL SMILE IS A WONDERFUL ASSET PLEASE FILL OUT THIS FORM COMPLETELY. THE BETTER WE COMMUNICATE, THE BETTER WE CAN CARE FOR YOU.

FRASERBRACES—LOVE YOUR SMILE
ERIC D. FRASER, DDS, MS
Orthodontics for Children and Adults

Today's Date: ____/____/____

ABOUT YOU

Email address: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ ☐Male ☐Female

Birthdate: ____/____/____ Age: ____ SS#: _____

Home Address: _____

_____
CITY STATE ZIP

☐Single ☐Widowed ☐Married ☐Divorced ☐Separated

Hm #: (___) _____ Cell #: (___) _____

Work #: (___) _____ Ext: _____ DL#: _____

Employer: _____

Employer Address: _____

How long there? _____ Occupation: _____

Where and when are best time to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

General Dentist: _____

Last Visit Date: _____

SPOUSE INFORMATION

His/Her Name: _____

Employer: _____

Work #: (___) _____ Ext: _____

SS#: _____ Birthdate: ____/____/____

Person Responsible For Account: _____

Work #: (___) _____ Ext: _____ Home #: (___) _____

Billing Address: _____

Relation: _____ SS #: _____

Employer: _____ DL #: _____

ORTHODONTIC INSURANCE

PRIMARY

Ortho 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

Ortho 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: _____

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

His/Her Name: _____ Relation: _____

Work #: (___) _____ Ext: _____ Home #: (___) _____

MEDICAL HISTORY

Do you have a personal physician? ☐Yes ☐No

Physician's Name: _____

Phone #: (___) _____ Date of Last Visit: _____

Your current physical health: ☐Good ☐Fair ☐Poor

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

Please explain: _____

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

Please list each one: _____

Continued on back

MEDICAL HISTORY CONTINUED

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	Congestive Heart Defect	☐Y	☐N	Mitral Valve Problem
☐Y	☐N	Diabetes	☐Y	☐N	Psychiatric Problems
☐Y	☐N	Difficult 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/Seisures/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	UlcersColitis
☐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	Metals/Plastic	☐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 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 experiences pain/discomfort in your jaw joint (TMJ/TMD)? ☐Yes ☐No

Your current dental health: ☐Good ☐Fair ☐Poor

Do you like your smile? ☐Yes ☐No

Gums ever bleed? ☐Yes ☐No

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

Do you have any speech problems? _____

Do you generally breath through your mouth? ☐Yes ☐No

If yes, please check: ☐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

Have you ever taken Phen-Fen? ☐Yes ☐No

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

I understand that the information 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 the 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

THANK YOU FOR FILLING OUT THIS FORM 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 this 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 deductible 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 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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