WELCOME
TO JOHNSON ORTHODONTICS

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.

1 About You

Today's Date: _____ E-mail Address: _____

Name: _____
Last First MI MR MRS MS DR

I prefer to be called _____ Male ___ Female ____

Birth date: ____/____/____ Age: ____ SS#: _____

Home Address: _____
Apt./Condo #

_____
City State Zip

Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐

Home #: _____ Cell #: _____

Work #: _____ Ext. _____ DL#: _____

Employer:_____

Employer's Address: _____

How long there? _____ Occupation: _____

When & where are best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

General dentist: _____ Last visit: _____

2 Spouse Information

His / Her Name: _____

Employer: _____

Work # _____ Ext. _____ Cell # _____

SS#: _____/_____/_____ Birth date: _____/_____/_____

Person Responsible for Account: _____

Work # _____ Ext. ____

Home # _____ Cell # _____

Billing Address: _____

Relation: _____ SS#: _____

Employer: _____ DL#: _____

3 Orthodontic Insurance

Primary

Orthodontic Insurance: ☐ Y ☐ N

Dental Coverage: ☐ Y ☐ N

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #:_____

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

Insured's Name: _____ Relation: _____

Insured's Birth date: _____ Insured's SS#: _____

Insured's Employer: _____

Secondary

Orthodontic Insurance: ☐ Y ☐ N

Dental Coverage: ☐ Y ☐ N

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #:_____

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

Insured's Name: _____ Relation: _____

Insured's Birth date:_____ Insured's SS#: _____

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

His/Her name: _____

Work #: _____ Home #: _____

Cell #: _____

! 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.

4 Medical History

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

Are you currently under the care of a physician? ☐ Y ☐ N

Please explain: _____

Taking any prescription/over the counter drugs? ☐ Y ☐ N

Please list each one: _____

For women: Are you taking birth control pills? ☐ Y ☐ N

Are you pregnant? ☐ Y ☐ N Week #:_____

Are you nursing? ☐ Y ☐ N

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 Defects	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/Freq. 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:_____

_____

5 Dental History

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

_____

Have you ever had or been evaluated for orthodontic treatment? ☐ Y ☐ N

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Y ☐ N

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ / TMD)? ☐ Y ☐ N

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

Do you like your smile? ☐ Y ☐ N

Gums ever bleed? ☐ Y ☐ N

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

Do you have any speech problems? _____

Do you generally breathe through your mouth? ☐ Y ☐ N

If yes, please circle: While awake? While asleep?

Do you have any missing or extra permanent teeth? ☐ Y ☐ N

Have you ever taken Phen-Fen? (Also known as Redux or Pondimin) ☐ Y ☐ N

If yes, when? _____

!

I understand that the information I have given today is correct to the best of my knowledge. I also understand that it 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 medical 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 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.

_____

Signature **Date**

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

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

Doctor's comments:

_____

_____

_____