

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? _____

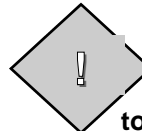
Do you generally breathe through your mouth? Y N

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? Y N
(Also known as Redux or Pondimin)

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.

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 _____

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:

