ABC
ORTHODONTICS
allison milliner, dds, ms

PATIENT INFORMATION

Today's Date:_____

Patient Name:_____Birthdate:_____Age:_____

If a patient is a minor, parent/guardian's name:_____

Mailing Address:_____

Home Phone:_____Work Phone:_____

Cell Phone:_____Email address:_____

Patient's School/Employer:_____Grade/Dept:_____

Hobbies/Sports/Musical Instruments:_____

Patient's Dentist:_____Referred by:_____

RESPONSIBLE BILLING PARTY INFORMATION

Name:_____Marital Status:_____

Mailing Address:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Relationship to Patient:_____Birthdate:_____SSN#:_____

Employer:_____Occupation:_____

Spouse's Name:_____Work or Cell Phone:_____

Relationship to patient:_____Birthdate:_____SSN#:_____

Employer:_____Occupation:_____

INSURANCE INFORMATION

Insured's Name:_____Insured's Member ID#:_____

Insurance Company:_____Phone #:_____

Insurance Company Address:_____

Insured's Employer:_____Group #:_____

Do you have secondary insurance coverage? **Yes** or **No** If yes, please fill out the below section:

Insured's Name:_____Insured's Member ID#:_____

Insurance Company:_____Phone #:_____

Insurance Company Address:_____

Insured's Employer:_____Group #:_____

EMERGENCY CONTACT INFORMATION

Name of nearest relative not living with you:_____

Address:_____

Phone:_____Relationship to patient:_____

MEDICAL HISTORY OF PATIENT

Has there been any history of asthma, blood disorders, breathing problems, cancer, diabetes, epilepsy, heart problems, HIV, joint swelling, kidney ailments, liver ailments, sensation or emotional difficulties, TB or any other illness we should be aware of?_____YES NO

If so, please describe:_____

Are you currently under the care of a physician?_____ YES NO

Do you currently take any medications? If yes, list:_____ YES NO

Do you have any allergies? (latex, nickel, acrylic, medications)_____ YES NO

Have you had any major surgeries or hospitalizations?_____ YES NO

Do you bleed easily or is bleeding hard to stop?_____ YES NO

Have you experienced any pain or clicking around the jaw joints?_____ YES NO

Do you suffer from frequent headaches?_____ YES NO

Women, are you pregnant or nursing?_____ YES NO

DENTAL HISTORY OF PATIENT

Approximate date of last dental visit:_____Date of last x-rays:_____

Have there been cavities in the past?_____ YES NO

Did any teeth abscess or cause gum loss?_____ YES NO

Do your gums bleed easily when you brush or floss?_____ YES NO

Any serious problems associated with previous dental treatment?_____ YES NO

Have there been any injuries to the teeth? (Chips, falls, blows, etc)_____ YES NO

Have any teeth been removed by extraction?_____ YES NO

Was it suggested that the space be maintained?_____ YES NO

Was an appliance placed?_____ YES NO

Do you breathe mainly through the mouth (are the lips usually parted)?_____ YES NO

Have you ever had a habit or thumb/finger sucking, tongue thrust or lip biting?_____ YES NO

Have you noticed any speech problems?_____ YES NO

Have you noticed any difficulty chewing food?_____ YES NO

Are you aware of grinding or clenching your teeth?_____ YES NO

Are you aware of any missing or extra teeth?_____ YES NO

Are you dissatisfied with the appearance of your teeth or other facial structures?_____ YES NO

Are you sensitive regarding statements concerning your facial/teeth appearance?)_____ YES NO

Has the patient seen an orthodontist before?_____ YES NO

If so, please describe_____

Has anyone in the family had orthodontic treatment?_____ YES NO

If so, please describe_____

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

_____

I understand that the information that I have given is correct to the best of my knowledge and that it will be held in the strictest confidence. I understand it is my responsibility to inform this office of any changes in the patient's medical and dental status. I authorize the orthodontic staff to take dental radiographs, study models or photos deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.

Patient/Parent/Guardian Signature:_____