BENNING AND MATHEWS ORTHODONTICS

WELCOME TO OUR PRACTICE

The following information is requested to enable us to give you the best consideration of your orthodontic treatment during your initial examination in our office. In order for our doctor(s) to thoroughly diagnose any condition, they must have accurate background and health information on which to base their decisions. This information, important for our records and your health, is CONFIDENTIAL.

PATIENT INFORMATION

Patient's Name________________________________ Date of Birth____/____/____ Age________ Sex________
Last, First, Middle
Social Security No. ______________________ Home Phone no. __________________ Patient's Height____________

Address____________________________________ City_____________________ State_______ Zip________

Whom may we thank for referring you to us?________________________ Patient's Physician______________________

Patient's General Dentist_________________________ Phone no. ________________ Date of last cleaning___/___/___

Please circle the most appropriate answer:

Marital Status:	Single	Married	Widowed	Separated	Divorced
Ethnicity:	Caucasian	Black	Latin	Asian	Other____________

Name of spouse or nearest relative________________________ Phone no.________________ Relationship________

Emergency Contact__________________________________Phone no. ________________ Relationship ________

Musical Instrument(s) played:___________________________ Hobbies & Activities___________________________

Employer_____________________________ Dept.______________ Work Phone no. _______________________

Work Address_____________________________________ City/St/Zip_________________________________

RESPONSIBLE PARTY INFORMATION

(If different from patient information.)

Name______________________________________ Date of Birth____/____/____ Age________ Sex________
Last, First, Middle
Social Security No. ______________________ Home Phone no. __________________ Relationship______________

Address____________________________________ City_____________________ State_______ Zip________

Employer_____________________________ Dept.______________ Work Phone no. _______________________

Work Address_____________________________________ City/St/Zip_________________________________

INSURANCE INFORMATION

Do you have dental or orthodontic insurance? Yes________ No_________ (If yes, complete the section below IN FULL)

Primary Insurance Carrier____________________________ Phone no. ________________ Group no. __________

Claims Address_____________________________________City/St/Zip_________________________________

Policy Holder____________________DOB___/____/_____ SS#______________Employer__________________

Secondary Insurance Carrier__________________________ Phone no. ________________ Group no. __________

Claims Address_____________________________________City/St/Zip_________________________________

Policy Holder____________________DOB___/____/_____ SS#______________Employer__________________

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Please answer each question by circling either Yes or No

MEDICAL HISTORY | DENTAL HISTORY

		MEDICAL HISTORY			DENTAL HISTORY
YES	NO	Birth defects or hereditary problems?	YES	NO	Chipped or otherwise injured permanent teeth?
YES	NO	Bone fractures, any major accidents?	YES	NO	Teeth sensitive to hot or cold? Throb or ache?
YES	NO	Rheumatoid or arthritic conditions?	YES	NO	Jaw fractures, cysts, mouth infections?
YES	NO	Endocrine or thyroid problems?	YES	NO	"Dead Teeth", root canals?
YES	NO	Kidney problems?	YES	NO	Bleeding gums, bad taste, mouth odor?
YES	NO	Diabetes?	YES	NO	Periodontal "Gum problems"?
YES	NO	Cancer or ever treated for a tumor?	YES	NO	Food impaction between teeth?
YES	NO	Stomach ulcer or hyperactivity?	YES	NO	"Gum Boils", frequent canker sores, cold sores?
YES	NO	Polio, mononucleosis, tuberculosis, pneumonia?	YES	NO	Thumb, finger, sucking habit? Until age:________________
YES	NO	Problems of the immune system?	YES	NO	Abnormal swallowing habit (tongue thrusting)?
YES	NO	Hepatitis, jaundice or liver problems?	YES	NO	Mouth breathing habit, snoring, difficult breathing?
YES	NO	AIDS or HIV Positive?	YES	NO	Tooth grinding, jaw clenching, clicking, locking?
YES	NO	Sexually transmitted disease?	YES	NO	Any pain or soreness in the face muscles or around your ears?
YES	NO	Fainting spells, seizures, epilepsy or neurologic disease?	YES	NO	Any jaw pain or ringing in the ears?
YES	NO	Mental health or behavioral problems?	YES	NO	Ever been treated for "TMD" or "TMJ" problems?
YES	NO	Vision, hearing, tasting or speech difficulties?	YES	NO	Difficulty in chewing or opening your jaw?
YES	NO	Loss of weight recently or poor appetite?	YES	NO	History or supernumerary (extra) or congenitally missing teeth?
YES	NO	Excessive bleeding, black and blue tendency, anemia or bleeding disorder?	YES	NO	Have you had any permanent teeth extracted?
YES	NO	High or low blood pressure?	YES	NO	Are you aware of any loose, broken or missing restorations or fillings?
YES	NO	Easily tired?	YES	NO	Any teeth irritating the cheeks, lips, tongue or palate?
YES	NO	Chest pain, shortness of breath or swelling ankles?	YES	NO	Have you recently been under another dentist's care?
YES	NO	Heart problems? If yes, describe:___________________________	YES	NO	Have you ever had periodontal (gum) treatment?
YES	NO	Skin disorder?	YES	NO	Concerned about spaced, crooked or protruding teeth?

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YES NO	Do you have a normal and good diet?	YES NO	Aware or concerned about under or over developed jaw?
YES NO	Frequent headaches, colds or sore throats?	YES NO	Any relative with a similar tooth or jaw relationship?
YES NO	Any history of speech problems?	YES NO	Any wisdom tooth problems?
YES NO	Eye, ear, nose, throat conditions?	YES NO	Any serious trouble associated with previous dental treatment?
YES NO	Hayfever, asthma, sinus trouble, hives?		
YES NO	Tonsil or adenoid conditions?		
YES NO	Allergies or drug reactions? If yes, describe:_________________		
YES NO	Taking medication, nutrient supplements or non-prescription medicines? If yes, describe:_______________________________		
YES NO	Do you currently have or ever had a substance abuse problem?		
YES NO	Operations? Hospitalizations? Describe:____________________		FEMALE PATIENTS ONLY
YES NO	Other physical problems or symptoms? Describe:_____________	YES NO	Are you pregnant?
YES NO	Currently being treated by another health care professional? If yes, for what condition?________________________________	YES NO	Are you taking birth control pills?
YES NO	Are you in good health? Date of most recent exam____/____/____	YES NO	Are you anticipating becoming pregnant?

Please add comments or additional explanation concerning your answers:____

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MISCELLANEOUS INFORMATION

1. Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment? Yes or No If Yes, please explain:____

2. Are you aware that most appointments will be scheduled during normal working hours and may infringe upon school or personal work schedule or time? Yes or No

Please give a brief description of the reason for your visit____

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PLEASE READ THIS PARAGRAPH CAREFULLY AND SIGN BELOW:

I have completed this form fully and completely and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though I may have orthodontic insurance coverage, I am fully responsible for all financial agreements and treatment fees. I further agree to pay any collection agency costs or legal fees associated with the collection of fees on my account that may become delinquent. I grant permission to you, or your assigns, to telephone me at home or at my office to discuss matters related to this form, fees, and treatment. I have read the above conditions of treatment and agree to their content.

Signed:______________________________ **Date:**______________

DO NOT WRITE BELOW – FOR OFFICE USE ONLY

EXAM NOTES:____

Fees:

New Patient Exam:______________

X-rays:______________

Treatment Cost:______________

- Initial Appliance Insertion Fee:______________
- Monthly payment:__________ for approx. ________ mos.
- Retainer/Retention Fee:______________

Upper Braces__________	WLLA__________
Lower Braces__________	FLLA__________
Upper H__________	Position__________
Lower H__________	OSAM__________
RPE__________	3x3__________
TPA 6__________	TPA 7__________
Upper Spl__________	Lower Spl__________
Lower Schwartz__________	Lower Fixed Trade______
Mouth Guard__________	