

# 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, which is important for our records and your health, is CONFIDENTIAL.

### PATIENT INFORMATION

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_  
Last, First, Middle

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_ Phone \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_ Patient's Physician \_\_\_\_\_

Patient's Dentist \_\_\_\_\_ Date of last cleaning \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Patient's Height \_\_\_\_\_

Father's Height \_\_\_\_\_ Mother's Height \_\_\_\_\_ Adopted ( Y or N) \_\_\_\_\_ Hobbies/Activities \_\_\_\_\_

Ethnicity: (please circle most appropriate) Caucasian Black Latin Asian Other \_\_\_\_\_

Patient lives with: \_\_\_\_\_ Phone \_\_\_\_\_

Nearest relative not living with patient: \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

### RESPONSIBLE PARTY INFORMATION

Correspondence Title: Mr. & Mrs \_\_\_\_\_ Mr. \_\_\_ Dr. \_\_\_ Ms. \_\_\_ Miss \_\_\_ Email address: \_\_\_\_\_

Responsible Party's Name \_\_\_\_\_ Phone \_\_\_\_\_

SS# \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Employer \_\_\_\_\_ Dept \_\_\_\_\_ Work Phone \_\_\_\_\_

Address \_\_\_\_\_ City/State/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 \_\_\_\_\_

# Benning and Mathews Orthodontics

## HEALTH QUESTIONNAIRE

Please answer each question. Circle **YES** or **NO** where applicable.

### MEDICAL HISTORY

1. Is the patient in good health? YES NO
2. Any history of illness? YES NO If yes, describe: \_\_\_\_\_
3. Please mark any of the following the patient has or was treated for:  
Diabetes \_\_\_\_\_ Tuberculosis \_\_\_\_\_ Endocrine Problems \_\_\_\_\_ Other \_\_\_\_\_  
Pneumonia \_\_\_\_\_ Anemia \_\_\_\_\_ Prolonged Bleeding \_\_\_\_\_  
Heart Trouble \_\_\_\_\_ Epilepsy \_\_\_\_\_ Dizziness \_\_\_\_\_  
Rheumatic Fever \_\_\_\_\_ Asthma \_\_\_\_\_ Nervous Disorders \_\_\_\_\_  
Bone Disorders \_\_\_\_\_ Kidney Disorders \_\_\_\_\_ Liver Disorders \_\_\_\_\_
4. Does the patient have a tendency towards:  
Colds \_\_\_\_\_ Sore Throats \_\_\_\_\_ Ear Infections \_\_\_\_\_ Headaches \_\_\_\_\_
5. Has the patient ever been exposed to: Herpes \_\_\_\_\_ AIDS \_\_\_\_\_ Hepatitis \_\_\_\_\_
6. Have the tonsils and adenoids been removed? YES NO If so, what age: \_\_\_\_\_
7. Is the patient currently under medical treatment? If yes, for what condition? \_\_\_\_\_
8. List any drugs or medications being taken \_\_\_\_\_
9. List any allergies or drug sensitivities \_\_\_\_\_

### DENTAL HISTORY

1. Are there other family members with similar orthodontic conditions? YES NO If so, whom? \_\_\_\_\_
2. Has the patient had any unusual dental experiences? YES NO If yes, explain: \_\_\_\_\_
3. Does the patient want their teeth straightened? YES NO
4. Have there been any injuries to the face or mouth? YES NO If yes, be specific: \_\_\_\_\_
5. Has the patient ever sucked a thumb or finger? YES NO If yes, until what age: \_\_\_\_\_
6. Does the patient have any speech problems? YES NO
7. Does the patient breath through the mouth while awake? YES NO ....or while asleep? YES NO
8. Have you been informed of any missing teeth? YES NO
9. Have you been informed of any extra permanent teeth? YES NO
10. Does the patient have: Jaw popping and/or pain? YES NO Frequent Headaches? YES NO
11. Does the patient clench or grind his or her teeth at night? YES NO
12. Have you previously consulted an orthodontist? YES NO
13. Has the patient received orthodontic treatment? YES NO If yes, name of orthodontist: \_\_\_\_\_

# Benning and Mathews Orthodontics

## MISCELLANEOUS INFORMATION

1. Are you aware that some appointments will infringe on school time?      YES      NO
2. Please give a brief description of reasons for your visit. \_\_\_\_\_  
\_\_\_\_\_

### 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 if the patient has orthodontic insurance coverage, I am still 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 any fees that should become delinquent on my account. I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form, fees, and treatment of the patient. 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 _____	