360 ORTHODONTICS

19053 Bagley Rd. Suite 1
Middleburg Heights, Ohio 44130
(440) 243-9575

PATIENT INFORMATION (please know that we respect and protect your privacy)

Preferred Name ______________________ Birthdate ______________________ Sex ____________

Home Address: Street ____

City ____________________ State________ Zip ________Home Phone ______________

Mobile Phone __________ Work Phone ____________D.L.#________________

Email address ______________________ Marital Status ____________________

Employer Name & Address____

How long there? __________ Occupation____________________________

Who may we thank for referring you? ______________________________

Other family members seen by us _________________________________

General Dentist ______________________ Phone ______________________

RESPONSIBLE PARTY INFORMATION

Last ________________________First __________________MI _____

Billing Address: ____

Relation __________________________SS#______________________

Employer __________________________DL# ______________________

EMERGENCY CONTACT INFORMATION

Name ____________________________Relation ___________________
Work #____________Mobile # ______________Home # ________________

PRIMARY & SECONDARY DENTAL INSURANCE – ORTHODONTIC BENEFITS: YES/NO

Insured's Full Name ____________________________ Birthdate ____________

SS# ________________ Relationship to Patient __________________________

Insurance Co________________________ Employer ____________________

Insurance Address __________________________ Ins Phone ______________

Contract ID ______________________ Group #_________________________

Insured's Full Name ____________________________ Birthdate ____________

SS# ________________ Relationship to Patient __________________________

Insurance Co________________________ Employer ____________________

Insurance Address __________________________ Ins Phone ______________

Contract ID ______________________ Group #_________________________

DENTAL HISTORY

Main concerns that you would like orthodontics to accomplish? ____________________

Have you ever been evaluated for orthodontic treatment? ____________________

Have you ever had a serious problem associated with any previous dental work? ____________________

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

Have you ever had an injury to face, mouth or teeth? ____________________

Do you have any missing or extra permanent teeth? ____________________

Have you ever taken Phen-Fen, Fosamax or any other bisphosphonate? ____________________

Please check any of the following conditions that apply:

☐ Bleeding	☐ False teeth	☐ Mouth breather	☐ Sensitivity to hot
☐ Bridgework	☐ Grinding teeth	☐ Partial dentures	☐ Sensitivity to biting
☐ Crowns	☐ Loose teeth	☐ Sensitivity to cold	☐ Smoke or use tobacco

MEDICAL HISTORY

Name of Physician ____________________ Date of Last visit ____________________

Please list all medications you are currently taking? ____________________

Allergies (drugs/latex/nickel/any other ____________________

(Women) Is patient pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control? ☐ Yes ☐ No

Have you ever had any of the following medical problems?

☐Abnormal bleeding	☐ Drug/alcohol abuse	☐ Hepatitis	☐ Radiation treatment
☐ Anemia	☐ Emphysema	☐ Blood Pressure H/L	☐ Rheumatic/Scarlet fever
☐ Artificial bones/joints/valves	☐ Epilepsy/Seizures/Fainting	☐ Heart attack/stroke	☐ Severe/frequent headaches
☐ Asthma/arthritis	☐ Fever Blisters/Herpes	☐ HIV+ /AIDS	☐ Shingles
☐ Blood transfusion	☐ Glaucoma	☐ Kidney problems	☐ Sickle cell disease/Traits
☐ Cancer/Chemotherapy	☐ Heart attack/Stroke	☐ Liver problems	☐ Sinus problems
☐ Chemotherapy	☐ Heart murmur	☐ Major surgery	☐ Tuberculosis (TB)
☐ Diabetes	☐ Heart surgery/Pacemaker	☐ Mitral valve Prolapse	☐ Ulcers/Colitis
☐ Difficulty breathing	☐ Hemophilia	☐ Psychiatric care	☐ Venereal disease

Please list any serious medical conditions that you have ever had ____________________
Please list any drugs/materials that you are allergic to ____________________

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. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office.

____________________ ____________________
Signature Date

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information 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 dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

____________________ ____________________
Signature Date