Dr. Clendenen DDS MS

Today's Date: _____

PATIENT INFORMATION:

_____
Last First Middle

Name Preferred: _____ ☐ Male ☐ Female Date of Birth: ____/____/____ Age: _____

Address: _____
City State Zip

Phone number: (This number will be used for appointment reminders) _____

Other family members seen in our office, and their relationship to the patient: _____

How did you hear about our office? (Please check all that apply)

- ☐ Your dentist
- ☐ Your hygienist
- ☐ Advertisement from child's school program
- ☐ Banner at school
- ☐ T-shirts worn in community
- ☐ Your neighbor _____
- ☐ Drive by
- ☐ Phone book
- ☐ Your friend _____
- ☐ Internet
- ☐ Staff member
- ☐ Family member _____
- ☐ Other _____

Orthodontic Concerns? _____

MOTHER'S INFORMATION: 1) Do you have legal custody of the child? ☐YES ☐NO 2) Does the child reside with you? ☐YES ☐NO

_____ Date of Birth: ____/____/____
Last First Middle

Address: _____
City State Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ IF MARRIED, SPOUSE'S NAME: _____

Employer: _____ Occupation: _____ How long there? _____

FATHER'S INFORMATION: 1) Do you have legal custody of the child? ☐YES ☐NO 2) Does the child reside with you? ☐YES ☐NO

_____ Date of Birth: ____/____/____
Last First Middle

Address: _____
City State Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ IF MARRIED, SPOUSE'S NAME: _____

Employer: _____ Occupation: _____ How long there? _____

IF THE PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

What school does the child attend? _____ Grade _____

Who is accompanying the child today? _____ Relation: _____

EMERGENCY CONTACT: In the event of an emergency, is there someone who lives near you that we should contact?

Name: _____ Relation: _____

Home #: _____ Work #: _____ Cell #: _____

FINANCIAL RESPONSIBLE PARTY INFORMATION: (This person must be present at time of contract signing)

_____ Date of Birth: _____/____/____
Last First Middle

Address: _____ City: _____ St: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ Social Security #: _____

Employer: _____ Occupation: _____ How long there? _____

PRIMARY DENTAL INSURANCE: Orthodontic Coverage? ☐ Yes ☐ No Maximum Amount: $ _____

Insurance Company Name: _____ Insurance Company Phone #: _____

Group #: _____ Employer: _____ ID#: _____

Insured's Name: _____ Relationship to Patient: _____

Insured's address: _____ Home phone: _____

Insured's Date of Birth: ___/___/___ Insured's Social Security #: _____

DENTAL ASSESSMENT/HISTORY: Patient's Dentist: _____ Last Visit: _____

Has an orthodontist been consulted previously? ☐ Yes ☐ No If Yes, explain: _____

Antibiotics required prior to dental visits? ☐ Yes ☐ No If Yes, explain: _____

Has the patient had any of the following dental problems? (Please circle Yes or No)

Jaw Joint Pain/Tenderness	☐ Yes	☐ No	Tooth/Jaw Trauma	☐ Yes	☐ No
Finger/Thumb Habit	☐ Yes	☐ No	Does your jaw lock open?	☐ Yes	☐ No
Do you grind your teeth at night?	☐ Yes	☐ No	Do you clench your teeth?	☐ Yes	☐ No
Lip/Tongue Biting	☐ Yes	☐ No	Tongue Thrust	☐ Yes	☐ No
Missing Permanent Teeth	☐ Yes	☐ No	Extra Permanent Teeth	☐ Yes	☐ No
Allergy to Dental Anesthetics	☐ Yes	☐ No	Allergy to Latex	☐ Yes	☐ No

MEDICAL ASSESSMENT/HISTORY: Patient's Physician: _____ Last Visit: _____

Does the patient have current or previous history of the following conditions? (Please circle Yes or No)

Abnormal Bleeding	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Plastic/Metal Allergy	☐ Yes	☐ No	Cancer or Tumor	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Fainting or Dizziness	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Epilepsy/Convulsions	☐ Yes	☐ No	Anemia	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Kidney/Liver Problems	☐ Yes	☐ No	Hearing Impairment	☐ Yes	☐ No	Mouth Breathing	☐ Yes	☐ No
Tonsils/Adenoid Problems	☐ Yes	☐ No	Chronic Sinus/Allergies	☐ Yes	☐ No	HIV +/AIDS	☐ Yes	☐ No
Chronic Headaches	☐ Yes	☐ No	Fever Blisters	☐ Yes	☐ No	Tobacco Use	☐ Yes	☐ No
Other Disabilities	☐ Yes	☐ No	Gastrointestinal problems	☐ Yes	☐ No	**Pregnant Now**	☐ Yes	☐ No

Please explain any previous, or ongoing, medical conditions, problems, surgeries, etc.:_____

_____

List any medications being taken, and their purpose: _____

_____

Please list any allergies to medications: _____

AFFIRMATION: I affirm that the information I have given is correct to the best of my knowledge. The information will be held in strictest confidence. It is my responsibility to inform this office immediately of any changes in medical status.
I certify that I am or my child, is covered by the above-listed insurance and assign directly to Sherman, Briscoe and Wilkinson Orthodontics all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of all information necessary to secure the payment of benefits, and the use of this signature on all insurance submissions, whether manual or electronic.

_____ _____
Signature of Responsible Party Date

FOR OFFICE USE ONLY: Treatment Coordinator: _____ Date: _____Blood Pressure: _____