Orthodontists

**Badger & Spiller**

Orthodontics for Children and Adults

## PATIENT INFORMATION

NAME: (last)______________ (first)______________ (mi) ________ (nickname) ______________

ADDRESS: ______________ City: ______________ State: ________ Zip: ________

PHONE: ______________ BIRTHDATE: _____ /_____ /_____ AGE: ________

E-MAIL ADDRESS: ______________

**HOW DID YOU HEAR ABOUT OUR OFFICE?**

- ☐ Web Search (Google, Bing, etc.)
- ☐ Reviews Site (Yelp, Angies List, etc.)
- ☐ Dentist Referral
- ☐ Personal Referral (Friend or family member)
- ☐ Saw Advertising Online
- ☐ I Knew From Community Activities (Sponsorships, Charity, etc.)

☐ Other: Please Explain ______________

SCHOOL YOU ATTEND: ______________

## RESPONSIBLE PARTY INFORMATION **(The person signing the contract will be the responsible party)**

NAME (last, first, mi):______________ MARITAL STATUS: ______________

ADDRESS (if different):______________

HOME PHONE # (if different): ______________

EMPLOYER:______________

WORKED FOR HOW LONG:______________ WORK PHONE #: ______________

## FAMILY INFORMATION **(Please complete only if patient is a minor)**

FATHER'S NAME: ______________

E-MAIL ADDRESS:______________

ADDRESS (if different):______________

EMPLOYER: ______________ HOW LONG: ________

PHONE #:______________

BUSINESS PHONE #: ______________

MOTHER'S NAME: ______________

E-MAIL ADDRESS: ______________

ADDRESS:______________

EMPLOYER: ______________ HOW LONG: ________

PHONE #: ______________

BUSINESS PHONE #:______________

## INSURANCE DENTAL INFORMATION **(Hoosier Healthwise does NOT cover Orthodontic Treatment)**

NAME OF INSURANCE:______________

INSURANCE ADDRESS: ______________

City: ______________ State______________ Zip ______________

INSURANCE PHONE #: ______________ GROUP #: ______________

NAME OF INSURED: ______________ BIRTHDATE: ________ SSN# ________

INSURED ID#: ______________ NAME OF EMPLOYER: ______________

**IF THERE IS A SECONDARY INSURANCE PLEASE ASK FOR ANOTHER FORM. THANKS**

## EMERGENCY INFORMATION

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU: ______________

ADDRESS: ______________

PHONE #: ______________ RELATIONSHIP:______________

## MEDICAL HISTORY

PHYSICIAN'S NAME ______________________________

**HAS PATIENT HAD ANY OF THE FOLLOWING (PLEASE MARK BOX)**

- ☐ HEART PROBLEMS/MURMUR
- ☐ HIGH BLOOD PRESSURE
- ☐ ARTIFICIAL HEART VALVES OR JOINTS
- ☐ DIABETES
- ☐ RESPIRATORY DISEASE
- ☐ EPILEPSY
- ☐ HEADACHES
- ☐ HEPATITIS LIVER DISEASE
- ☐ EMOTIONAL DISORDERS
- ☐ ALLERGIES TO MEDICINE ______________
- ☐ GENERAL ALLERGIES
- ☐ TONSILLITIS
- ☐ AIDS (AUTOIMMUNE DISEASES)
- ☐ VENEREAL DISEASE
- ☐ HEMOPHILIA (BLEEDING DISORDERS)
- ☐ RHEUMATIC FEVER
- ☐ RECENT UNEXPECTED WEIGHT LOSS
- ☐ OTHER, SPECIFY ______________

PRESENT STATE OF HEALTH: ☐ **EXCELLENT** ☐ **GOOD** ☐ **POOR**

IS PATIENT TAKING MEDICINE AT THIS TIME? ☐ **YES** ☐ **NO** IF SO, WHAT? ______________

______________________________

IS PATIENT PRESENTLY UNDER PHYSICIAN'S CARE? ☐ **YES** ☐ **NO** WHAT CONDITION? ______________

IF PATIENT IS A CHILD WHAT IS HIS/HER WEIGHT?______________ HEIGHT? ______________

IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT YOUR MEDICAL HISTORY? ______________

REVIEWED______________________________ DATE ______________

## DENTAL HISTORY

NAME OF YOUR DENTIST: ______________________________

**HAS PATIENT HAD ANY OF THE FOLLOWING (PLEASE MARK BOX)**

- ☐ RECENT DENTAL X-RAYS
- ☐ TEETH CLEANED RECENTLY
- ☐ FLUORIDE TREATMENT
- ☐ PREVIOUS ORTHODONTIC CONSULTATION
- ☐ PERIODONTAL TREATMENT
- ☐ RECENT FILLINGS, CROWNS
- ☐ TRAUMA TO FACE/MOUTH
- ☐ IMPRESSIONS
- ☐ DENTAL CHECK UP
- ☐ TMJ SPLINT

WHAT DO YOU CONSIDER THE MAIN BENEFIT OF ORTHODONTIC TREATMENT? ☐ **FUNCTIONAL** ☐ **COSMETIC** ☐ **PSYCHOLOGICAL**

IS PATIENT SELF-CONSCIOUS OF HIS/HER TEETH? ☐ **YES** ☐ **NO**

HAVE WE TREATED OTHERS IN YOUR FAMILY? ☐ **YES** ☐ **NO** WHO?______________

**DOES PATIENT HAVE PAST/PRESENT HISTORY OF (PLEASE MARK BOX)**

- ☐ TONGUE THRUST
- ☐ THUMB SUCKING
- ☐ FINGER SUCKING
- ☐ NAIL BITING
- ☐ MOUTH BREATHING
- ☐ SPEECH IMPEDIMENT
- ☐ TMJ
- ☐ POPPING, CLICKING IN JAW JOINT

**THIS FORM WAS COMPLETED BY: (CIRCLE) PATIENT PARENT GUARDIAN**

**SIGNATURE:** ______________________________ DATE:______________

I,______________________________ have received a copy of this offices privacy practices

______________________________

Please Print Name

______________________________

Signature Date