



## Welcome to our practice!

Thank you for selecting our Orthodontic Team! We will strive to provide the best possible orthodontic care. To help us meet your needs, please fill out this form completely. If you have any questions or need assistance, please do not hesitate to ask. We will be happy to help.

### Patient Information

Name: \_\_\_\_\_ I Prefer to be called: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
The best time to contact me is: \_\_\_\_\_ on my  Home phone  Work phone  Cell phone  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Check Appropriate Box:  Minor  Single  Married  Widowed  Separated  Divorced  
Name of School \_\_\_\_\_ City \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
Person to contact in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_  
Email Address \_\_\_\_\_

### Responsible Party Information

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Employer \_\_\_\_\_ SSN# \_\_\_\_\_  
Driver's License# \_\_\_\_\_

### Insurance Information

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ SSN#: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_  
Insurance Address: \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

### Insurance Authorization

I certify that I am covered by \_\_\_\_\_ insurance company and I assign directly to Causey C. Lee, DDS, all insurance benefits, otherwise payable to me, for services rendered. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance coverage does not cover. I hereby release the dentist to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Patient Medical History

Are you currently under a physician's care?  Yes  No If yes, explain \_\_\_\_\_

Are you currently taking any medication?  Yes  No If yes, list \_\_\_\_\_

Are you allergic to any of the following?  Penicillin  Latex Gloves Other \_\_\_\_\_

### Any history of the following?

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Frequent colds      | <input type="checkbox"/> Sore Throats   | <input type="checkbox"/> Major Surgery     | <input type="checkbox"/> History of Major Illness |
| <input type="checkbox"/> Frequent Sinusitis  | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Hyperactivity     | <input type="checkbox"/> Anemia/Leukemia          |
| <input type="checkbox"/> Low Blood Pressure  | <input type="checkbox"/> Asthma         | <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Epilepsy/Convulsions     |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Smoker         | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> AIDS/HIV Infection       |
| <input type="checkbox"/> Allergies           | <input type="checkbox"/> Hepatitis      | <input type="checkbox"/> Heart Disease     | <input type="checkbox"/> Psychiatric problems     |

Other: \_\_\_\_\_

## Patient Dental History

Dentist: \_\_\_\_\_ City: \_\_\_\_\_ Last Exam: \_\_\_\_\_

Have you had a dental check-up in the last 6 months?  Yes  No

Have you had any injuries to the face, mouth or teeth?  Yes  No

Do you need to take antibiotics for Dental work?  Yes  No

Do you experience pain/discomfort in your jaw joint?  Yes  No

Have you had your 3<sup>rd</sup> Molars/Wisdom teeth removed?  Yes  No

Have you ever had Orthodontic Treatment?  Yes  No

Do you have any of the following habits?

- Thumb/Finger Sucking  Lip Biting  Lip sucking  Teeth Grinding  Clenching Teeth

### Chief Dental Complaints:

- |  |  |                                      |   |                                   |
|--|--|--------------------------------------|---|-----------------------------------|
| <input type="checkbox"/> Crowding      | <input type="checkbox"/> Spacing           | <input type="checkbox"/> Overbite    | <input type="checkbox"/> Underbite      | <input type="checkbox"/> Grinding |
| <input type="checkbox"/> Clenching     | <input type="checkbox"/> Speech Problems   | <input type="checkbox"/> Receded Jaw | <input type="checkbox"/> Prominent Jaw  | <input type="checkbox"/> TMJ      |
| <input type="checkbox"/> Missing Teeth | <input type="checkbox"/> Facial Proportion | <input type="checkbox"/> Gummy Smile | <input type="checkbox"/> Excessive Wear |                                   |

What are the main concerns you would like for orthodontics to accomplish? \_\_\_\_\_

## Authorization

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical or dental status.

Signature \_\_\_\_\_ Date \_\_\_\_\_