Orthodontic Solutions
for Children & Adults

Welcome to our office!

In an effort to provide the best service possible, we ask you to fill out this form as completely as possible.

Patient Information

Patient's Name _____ Age_____ Birth Date_____
First Middle Last

Nickname (if preferred)_____ ○ Male ○ Female E-mail Address_____

Home Phone_____ Cell Phone_____Work Phone_____

Home Address_____ City, State, Zip_____
Number Street

Employer_____

Occupation_____ How Long? _____ SS#_____

General Dentist_____
Name Address

How did you hear about our office?_____ Have we treated another family member? ○ Yes ○ No

What are the main concerns you would like orthodontics to address?_____

Have you visited an orthodontist before? ○ Yes ○ No If Yes, for what reason? _____

Is there anything you would like to discuss with the doctor in private? ○ Yes ○ No

Insurance Information

Marital Status ○ Single ○ Married ○ Widowed ○ Divorced ○ Separated ○ Domestic Partner

Is there anyone who helps you make your healthcare decisions? _____

Primary Dental Coverage

Dental Insurance Company_____ Group or Plan #_____

Insured's Name_____ Insured's Birth Date_____

Relationship to patient_____ Insured's ID #_____

Insured's Employer _____ SS# if no ins card available_____

Secondary Dental Coverage

Dental Insurance Company_____ Group or Plan #_____

Insured's Name_____ Insured's Birth Date_____

Relationship_____ Insured's ID #_____

Insured's Employer _____ Employer's City, State_____

Dental and Medical History

Are you currently under the care of a physician? ○ Yes ○ No If yes, for what reason? _____

Physician _____ Phone # _____

History of major illness? ○ Yes ○ No If yes, please describe_____

Any sensitivities or allergies? ○ Yes ○ No If yes, please list _____

Currently taking any medications? ○ Yes ○ No If yes, please list _____

Have you been treated for any of the following?

☐ Arthritis ☐ Blood Disorder ☐ Diabetes ☐ Heart Condition ☐ Tuberculosis ☐ Chance of Pregnancy
☐ Asthma ☐ Cancer ☐ Epilepsy ☐ Nervous Disorder ☐ Other_____

Do you receive regular dental care? ○ Yes ○ No When was the last check up? _____

Do you tolerate routine dental procedures well? ○ Yes ○ No

Do you require antibiotics before dental treatment? ○ Yes ○ No If yes, explain_____

Have you been informed of extra or missing permanent teeth? ○ Yes ○ No

Have there been injuries to your face, mouth, teeth or chin? ○ Yes ○ No

Have you had pain/tenderness in the jaw joint (TMJ/TMD)? ○ Yes ○ No

Do you have any of the following habits?

☐ Speech Problems ☐ Chewing pens/pencils ☐ Chewing or Eating Difficulty
☐ Lip Biting ☐ Nail Biting ☐ Prolonged Finger/Thumb Sucking (to what age? _____)
☐ Mouth Breather ☐ Grinding/Clenching ☐ Prolonged Bottle/Pacifier (to what age? _____)

Is there anything else that you feel we should know? _____

_____

Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes in my medical status.

I authorize Dr. Linda Krebs' office to submit insurance claims on my behalf and the release of any information related to insurance claims. I consent to examination by the doctor and I authorize payment of any insurance benefits. The insured/patient authorizes the insurance company to pay the provider directly. All deductibles, co-payments, and denied claims will be the total responsibility of the patient.

Signature_____ Date_____

Thank you!