

4320 McAuley Blvd.  
Oklahoma City, OK 73120  
(405) 755-8151



923 S. Main St.  
Kingfisher, OK 73750  
(405) 375-5328

## 1 TELL US ABOUT YOURSELF

Today's Date: \_\_\_\_\_ SSN: \_\_\_\_\_  
Your Full Name: \_\_\_\_\_  
Nickname: \_\_\_\_\_  Male  Female  
Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_  
Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Work #: (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_  
Your Home Address: \_\_\_\_\_  
\_\_\_\_\_

E-mail Address: \_\_\_\_\_  
 Single  Married  Divorced  Sep.  Widowed

Employer: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
\_\_\_\_\_

Job Title: \_\_\_\_\_  
Where & when are best times to reach you?  
\_\_\_\_\_

Whom may we thank for referring you?  
\_\_\_\_\_

Other family members seen by us: \_\_\_\_\_  
\_\_\_\_\_

General dentist: \_\_\_\_\_  
Date of Last Visit: \_\_\_\_\_

## 2 SPOUSE INFORMATION

His/Her Name: \_\_\_\_\_  
Birthdate: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Work # \_\_\_\_\_ Ext: \_\_\_\_\_  
Job Title: \_\_\_\_\_  
SSN #: \_\_\_\_\_

## 3 PERSON RESPONSIBLE FOR ACCOUNT

You  Your Spouse

Billing Address: \_\_\_\_\_  
\_\_\_\_\_

## 4 WHO TO CONTACT IN AN EMERGENCY

Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
Work #: \_\_\_\_\_ Ext: \_\_\_\_\_  
Home #: \_\_\_\_\_  
Personal Physician: \_\_\_\_\_  
Phone #: \_\_\_\_\_  
Date of last visit: \_\_\_\_\_

## 5 ORTHODONTIC INSURANCE

Orthodontic coverage?  Yes  No

Primary Dental Insurance: \_\_\_\_\_

Policy Holder: \_\_\_\_\_

Address: \_\_\_\_\_

ID#: \_\_\_\_\_ GR#: \_\_\_\_\_

Secondary Dental Insurance: \_\_\_\_\_

Policy Holder: \_\_\_\_\_

Address: \_\_\_\_\_

ID#: \_\_\_\_\_ GR#: \_\_\_\_\_

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

## 6 DENTAL HISTORY

\* What is your main concern with regard to your teeth? \_\_\_\_\_  
\_\_\_\_\_

\* Have you ever had or been evaluated for orthodontic treatment?  Yes  No

\* Have you ever had a serious or difficult problem associated with any previous dental work?  Yes  No

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

\* Have you previously had your wisdom teeth extracted?  Yes  No

Check out our web page: [www.okcbraces.com](http://www.okcbraces.com)

## DENTAL HISTORY, continued.

Do you now or have you ever experienced pain/clicking/locking of your jaw joint(s)?  Y  N

Your current dental health is:  Good  Fair  Poor

Do you like your smile?  Y  N

Do your gums ever bleed?  Y  N

Any speech problems?  Y  N

Any missing or extra permanent teeth?  Y  N

Have you ever had an injury to your:  Mouth  Teeth  Chin

Do you breathe through your mouth?  Y  N If so, when?  While awake  When asleep

Do you snore?  Y  N Chew gum often?  Y  N Smoke?  Y  N Chew tobacco?  Y  N

## 7 HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING MEDICAL PROBLEMS?

- |   |                                    |   |                           |
|---|------------------------------------|---|---------------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N | Bleeding / Clotting disorder       | <input type="checkbox"/> Y <input type="checkbox"/> N | Convulsions / Epilepsy    |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Handicaps / Disabilities           | <input type="checkbox"/> Y <input type="checkbox"/> N | Mouth Sores               |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Any hospital stays                 | <input type="checkbox"/> Y <input type="checkbox"/> N | Hearing Impairment        |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Any surgeries                      | <input type="checkbox"/> Y <input type="checkbox"/> N | ADD / ADHD                |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Artificial bones / joints / valves | <input type="checkbox"/> Y <input type="checkbox"/> N | Hepatitis                 |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Asthma                             | <input type="checkbox"/> Y <input type="checkbox"/> N | HIV+ / AIDS               |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Cancer                             | <input type="checkbox"/> Y <input type="checkbox"/> N | Kidney / Liver problems   |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Congenital heart defect            | <input type="checkbox"/> Y <input type="checkbox"/> N | Rheumatic / Scarlet fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Heart murmur                       | <input type="checkbox"/> Y <input type="checkbox"/> N | Sickle Cell disease       |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Diabetes                           | <input type="checkbox"/> Y <input type="checkbox"/> N | Tuberculosis              |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Drug reaction _____                | <input type="checkbox"/> Y <input type="checkbox"/> N | Latex or Metal allergy    |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Other medical problem(s) _____     |   |                           |

Please describe your current physical health:  Good  Fair  Poor

Please list all the drugs you are currently taking:

Please list all the drugs you are allergic to: \_\_\_\_\_

## 8 DO YOU NOW, OR HAVE YOU EVER EXHIBITED ANY OF THE FOLLOWING HABITS?

- |   |                          |   |                      |
|---|--------------------------|---|----------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N | Lip sucking or biting    | <input type="checkbox"/> Y <input type="checkbox"/> N | Nail biting          |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Teeth grinding/clenching | <input type="checkbox"/> Y <input type="checkbox"/> N | Thumb/finger sucking |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Tongue thrusting         |   |                      |

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

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
Date

*I authorize the dental staff to perform the necessary orthodontic services I may need.*

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
Date

The patient is responsible for payment at the time of service, unless prior arrangements have been approved by our Business Manager.

OFFICE USE ONLY... OFFICE USE ONLY... OFFICE USE ONLY... OFFICE USE ONLY... OFFICE USE ONLY... OFFICE USE ONLY...

*I verbally reviewed the medical/dental information above with the parent/guardian of this parent.*

\_\_\_\_\_  
Initials

\_\_\_\_\_  
Date