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

Heim ORTHODONTICS

Matt Heim, D.D.S., M.S., P.C.

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

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?

Y	N	Bleeding / Clotting disorder	Y	N	Convulsions / Epilepsy
Y	N	Handicaps / Disabilities	Y	N	Mouth Sores
Y	N	Any hospital stays	Y	N	Hearing Impairment
Y	N	Any surgeries	Y	N	ADD / ADHD
Y	N	Artifical bones / joints / valves	Y	N	Hepatitis
Y	N	Asthma	Y	N	HIV+ / AIDS
Y	N	Cancer	Y	N	Kidney / Liver problems
Y	N	Congenital heart defect	Y	N	Rheumatic / Scarlet fever
Y	N	Heart murmur	Y	N	Sickle Cell disease
Y	N	Diabetes	Y	N	Tuberculosis
Y	N	Drug reaction _____	Y	N	Latex or Metal allergy

Y 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?

Y	N	Lip sucking or biting	Y	N	Nail biting
Y	N	Teeth grinding/clenching	Y	N	Thumb/finger sucking
Y	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*