Patient Information

Name:_____
Nickname:_____
Birthdate:_____ Age:_____
Address:_____
City/State/Zip_____
Hm #_____ Cell#:_____
Primary E-mail:_____
Dentist:_____
Referred by:_____
Children/Siblings & Ages:_____
_____
Employer:_____Job Title:_____
Marital Status/Spouse:_____

If the Patient is under 18:

School:_____Grade: _____
Hobbies/Sports:_____
Parent's Marital Status:_____
✯Mother's Name:_____
SSN:_____DL#: _____
Birthdate:_____ Age:_____
Hm #_____ Cell#:_____
Employer:_____Job Title:_____
✯Father's Name:_____
SSN:_____DL#: _____
Birthdate:_____ Age:_____
Hm #_____ Cell#:_____
Employer:_____Job Title:_____

Who is responsible for this account:

☐ Patient ☐ Mother ☐ Father ☐ Other:_____

Primary Insurance

Orthodontic Coverage? **Yes**_____ **No**_____
Ins. Co. Name:_____
Ins. Co. Address:_____
Insurance Co. Phone#:_____
Group/Policy #_____
Policy Owner's Name:_____
D/O/B:_____SSN#:_____
Policy Owner's Employer:_____
Employer's Address:_____

Smile Questionnaire

In order to evaluate your needs and expectations as accurately as possible, please help us by answering the following questions:

Do you feel that your teeth are (circle all responses):

Too small or short?	**No**	**Yes**
Too large or long?	**No**	**Yes**
Crooked or crowded?	**No**	**Yes**
Misshaped (uneven/pointed)?	**No**	**Yes**
Off Color?	**No**	**Yes**

Do you feel your front teeth "stick out too much" (Buck Teeth)? **No** **Yes**

Have you ever injured your face, mouth, teeth or chin? **No** **Yes**

Are there spaces between your teeth that you do not like? **No** **Yes**

Is there too much or too little gum tissue showing when you smile? **No** **Yes**

Has there been previous orthodontic treatment (including braces/appliances)? **No** **Yes**

If so, when and by whom?_____
_____

Are there other dental issues not listed above that you would like to discuss or have treated? **No** **Yes**
(explain)_____

Have you ever experienced any of the following:

Clenching/Grinding teeth	Speech Problems
Thumb/Finger Sucking	Tongue Thrust
TMJ/Jaw Joint Pain	Other Oral Habits

Secondary Insurance

Orthodontic Coverage? **Yes**_____ **No**_____
Ins. Co. Name:_____
Ins. Co. Address:_____
Insurance Co. Phone#:_____
Group/Policy #_____
Policy Owner's Name:_____
D/O/B:_____ SSN#:_____
Policy Owner's Employer:_____
Employer's Address:_____

FOR OFFICE USE ONLY

DATE:_____
Orthodontic Ded._____ Orthodontic Max._____
Ortho coverage _____% Ortho age limit_____
Waiting periods_____ Benefits used_____

DATE:_____
Orthodontic Ded._____ Orthodontic Max._____
Ortho coverage _____% Ortho age limit_____
Waiting periods_____ Benefits used_____

Medical History

Patient's Name:_____

Please list any prescription/over-the-counter drugs that you/your child is currently taking:_____

_____

Please list all drugs/things that you/your child is allergic to:_____

_____

Latex Y N Metals/Nickel Y N Plastics Y N

WOMEN: Are you Pregnant? Y N

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

_____

SIGNATURE DATE

PATIENT ACKNOWLEDGEMENT

I hearby acknowledge that I have received and reviewed the Privacy Notice regarding the office of Scott S. Heying, D.D.S., M.S., P.A.

_____

SIGNATURE DATE

Has the patient ever had any of the following diseases or medical problems:

Y	N	Abnormal Bleeding	Y	N	Herpes/Fever Blisters
Y	N	Adenoids/Tonsils removed	Y	N	High Blood Pressure
Y	N	AIDS	Y	N	HIV
Y	N	Alcohol/Drug Abuse	Y	N	Hospitalized for Any Reason
Y	N	Arthritis	Y	N	Kidney Problems
Y	N	Artificial Bones/Joints/Valves	Y	N	Liver Disease
Y	N	Asthma	Y	N	Low Blood Pressure
Y	N	Blood Transfusion	Y	N	Lupus
Y	N	Cancer/Chemotherapy	Y	N	Mitral Valve Prolapse
Y	N	Colitis	Y	N	Pacemaker
Y	N	Congenital Heart Defect	Y	N	Psychiatric problems
Y	N	Diabetes	Y	N	Radiation Treatment
Y	N	Difficulty Breathing	Y	N	Rheumatic/Scarlet Fever
Y	N	Emphysema	Y	N	Seizures
Y	N	Epilepsy	Y	N	Shingles
Y	N	Fainting Spells	Y	N	Sickle Cell Disease/Traits
Y	N	Frequent Headaches	Y	N	Sinus Problems
Y	N	Glaucoma	Y	N	Stroke
Y	N	Hay Fever	Y	N	Thyroid Problems
Y	N	Heart Attack/Surgery	Y	N	Tuberculosis (TB)
Y	N	Heart Murmur	Y	N	Ulcers
Y	N	Hepatitis	Y	N	Veneral Disease

Any other medical conditions not listed above:

_____

_____