MARK JOINER, D.D.S. ORTHODONTICS FOR CHILDREN AND ADULTS

A B C

Confidential Patient Information

Date ______________________________

Patient's Name ______________________________
Last First Middle

Address ______________________________
Street City State Zip

Home Phone ______________ Birthdate ______________ Social Security ______________

Whom may we thank for referring you to our office? ______________________________

Confidential Responsible Party Information

Name ______________________________
Last First Middle Marital Status

Residence ______________________________
Street City State Zip

Mailing Address ______________________________
Street City State Zip

How long at this address? __________ Home Phone ______________ Work Phone ______________

Previous Address (if less than 3 yrs.) ______________________________
Street City State Zip

Email ______________________________ Cell Phone ______________

Social Security # ______________ Birthdate ______________ Relationship to Patient ______________

Employer ______________ Occupation ______________ No. Years Employed __________

Spouse's Name ______________________________ Relationship to Patient ______________
Last First Middle

Employer ______________ Occupation ______________ No. Years Employed __________

Social Security # ______________ Birthdate ______________ Work Phone ______________

Email ______________________________ Cell Phone ______________

Orthodontic Insurance Information

Insured's Name ______________________________ Insured's Soc. Sec. # ______________

Insurance Company ______________ Group No. ______________ I.D. No. ______________

Insurance Co. Address ______________________________

Do you have dual coverage? Yes ☐ No ☐ If yes: ______________________________

Insured's Name ______________________________ Insured's Soc. Sec. # ______________

Insurance Co. ______________ Group No. ______________ I.D. No. ______________

Insurance Co. Address ______________________________

Insured's Employer ______________________________

Emergency Information

Name of nearest relative/friend not living with you ______________________________ Relationship ______________

Complete Address ______________________________

Phone ______________________________ Cell Phone ______________________________

CONFIDENTIAL (for record and pre-treatment evaluation)

(Over)

Medical History

Physician's name ____________________ Date of last visit ____________

Yes	No	
☐	☐	Have you ever been hospitalized?
☐	☐	Have you ever had major surgery?
☐	☐	Are you presently under a physician's care for any condition?
☐	☐	Are you taking any drugs or medications?
☐	☐	Have the tonsils or adenoids been removed?
☐	☐	Do you have fainting or dizzy spells?

Have you been diagnosed or treated for any of the following?

Yes	No		Yes	No	
☐	☐	Heart problems	☐	☐	Kidney problems
☐	☐	Allergies	☐	☐	Liver problems
☐	☐	Rheumatic fever	☐	☐	Hepatitis
☐	☐	Lung problems	☐	☐	Exposure to AIDS
☐	☐	Asthma	☐	☐	Diabetes
☐	☐	Bone problems	☐	☐	Prolonged bleeding
☐	☐	Epilepsy	☐	☐	Psychological problems
☐	☐	Arthritis	☐	☐	Anemia
☐	☐	Tuberculosis	☐	☐	Sleep Apnea

Please describe any pertinent medical history below:

____

____

____

____

Dental History

Dentist's name ____________________ Date of last visit ____________

Yes	No	
☐	☐	Are you apprehensive about dental visits?
☐	☐	Have there been injuries to the mouth or teeth?
☐	☐	Do you have any speech problems?
☐	☐	Do you breathe predominantly through the mouth?
☐	☐	Do you experience frequent headaches?
☐	☐	Any clicking or pain in the jaw joints (TMJ)?
☐	☐	Do you clench or grind your teeth?
☐	☐	Do you know of any extra permanent teeth?
☐	☐	Do you know of any missing permanent teeth?
☐	☐	Is there bleeding during brushing or flossing?
☐	☐	Have you been told you have gum disease?
☐	☐	Have other family members had orthodontics? Who?______________________
☐	☐	Have you previously had an orthodontic evaluation or treatment? Orthodontist:______________________
☐	☐	Are you concerned about the appearance of your teeth?
☐	☐	Are there any other dental/orthodontic problems Dr. Joiner should be aware of? ____________

____

____

____

Please give us an idea of your hobbies and interests:

____

____

____

____

Please list names and ages of any children of yours:

Name	Age

What seems to be your main orthodontic problem? ______________________________

____

How would you describe your attitude toward possible orthodontic treatment? ______________

____

I represent that the information on this form is accurate and correct. If there is a change in the information I have provided, I will promptly notify the office. I understand that where appropriate, credit bureau reports may be obtained.

Signature ______________________________ Date______________

Updates (date & initial) ______________________________________