SPILLERS ORTHODONTICS

PATIENT FORM

PATIENT'S CONTACT INFORMATION

Patient First Name:_____Middle:_____Last:_____

Nickname:_____ ☐Male ☐Female SS#_____-_____-_____DOB:_____/_____/_____

Address:_____City:_____State:_____Zip:_____

Phone Number:_____Work Phone:_____Other Phone:_____

Email Address:_____

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

Other family members seen by us:_____

RESPONSIBLE PARTY INFORMATION

Patient (if adult), Spouse, Parent, or Guardian Name

First Name:_____Middle:_____Last:_____

Residence Address: ☐ Same as above Years at this address:_____

Address:_____City:_____State:_____Zip:_____

Mailing Address (if different):

Address:_____City:_____State:_____Zip:_____

Primary Phone:_____Work Phone:_____Other Phone:_____

Email Address:_____SS#_____-_____-_____DOB:_____/_____/_____

Relationship to Patient:_____Employer:_____

Occupation:_____Number of Years Employed:_____

DENTAL INSURANCE INFORMATION

☐ No Dental Insurance

Insured's First Name:_____Middle:_____Last:_____

DOB:_____/_____/_____ Insured's SS#_____-_____-_____Employer:_____

Dental Insurance Co:_____Group #_____ID#_____

Address:_____City:_____State:_____Zip:_____

Insurance Phone Number:_____

☐ Check if you have dual coverage

Second Insured's First Name:_____Middle:_____Last:_____

Second Insured's DOB:_____/_____/_____ SS#_____-_____-_____Employer:_____

Dental Insurance Co:_____Group #_____ID#_____

Address:_____City:_____State:_____Zip:_____

Second Insurance Phone Number:_____

EMERGENCY CONTACT

Name of the nearest relative NOT living with you:_____

Address:_____City:_____State:_____Zip:_____

Relationship:_____Primary Phone:_____Optional Phone:_____

PATIENT'S MEDICAL HISTORY

Physician:_____

☐ Currently Taking Medication:_____

☐ Allergy to Medication:_____

☐ History of Major Illness:_____

☐ Major Operations:_____

☐ ADHD ☐ Autism or Asperger's Syndrome ☐ Bone Disorders ☐ Diabetes ☐ Heart Condition

☐ Hepatitis/Liver Problems ☐ HIV/Aids ☐ Psychological, Behavioral or Developmental Issues

☐ Must pre-medicate with an antibiotic before having teeth cleaned

PATIENT'S DENTAL HISTORY

Regular Dentist:_____Date of Last Visit:_____(Month/Year)

Please note any known needed restorations or fillings:_____

Is the patient scheduled for the above procedures? ☐ Yes ☐ No ☐ N/A

Please explain any of the following which apply to the patient with relevant comments.

☐ Presently in dental pain:_____

☐ Past injuries to face, mouth or teeth:_____

☐ Any type of oral habit:_____

ABOUT TODAY'S VISIT

If today's evaluation reveals a need for treatment, what option are you most interested in? (Invisalign, Invisalign Teen, Metal or Clear Braces, etc.) _____

What is your number one concern with your smile?_____

What motivated you to come in at this time?_____

How did you first hear about our office?_____

What is your previous experience seeing an orthodontist?_____

Are there medical, allergy, psychological or special needs that our office should be aware of?_____

_____

Your Name_____Signature_____Date_____