Date ____________

Smith ORTHODONTICS | more than a smile

Brian Smith DDS, MSD

PATIENT WELCOME FORM

Patient's Name: Last ____________ First ____________ Nickname ____________

Address ____________ City ____________ State ______ Zip ________

Home Phone ____________ Cell Phone ____________ Business Phone _______

E-mail address of party whom we should correspond with ____________

☐ Male ☐ Female Date of Birth ____________ Age: Years ________ Months ________ Adopted? ____________

School ____________ Grade ____________ Musical Instrument? ____________

Special Interests ____________

Occupation ____________ Employer ____________

Dad/Husband's Name ____________ Dad's Home Phone ____________ Dad's Cell Phone ____________

Dad's Address ____________ City ____________ State ______ Zip ________

Dad's Occupation ____________ Employer ____________ Business Phone ____________

Mom/Wife's Name ____________ Mom's Home Phone ____________ Mom's Cell Phone ____________

Mom's Address ____________ City ____________ State ______ Zip ________

Mom's Occupation ____________ Employer ____________ Business Phone ____________

Responsible Party Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Siblings or Children (Names and Dates of Birth) ____________

____

____

Responsible Party Years at Current Employer: ____________

Responsible Party Years at Current Employer: ____________

Relatives treated by Dr. Smith ____________

Did your dentist give you Dr. Smith's name? ○ Yes ○ No Did a friend give you Dr. Smith's name? ○ Yes ○ No If so, who?

Patient's dentist ____________ Patient's physician ____________

Primary reason you are seeking treatment: ____________

Have you had any previous orthodontic consultations or treatment? ____________

Insured Party ____________ Social Security # of Insured ____________ Birth date of insured ____________

Do you have orthodontic insurance coverage? ○ Yes ○ No ○ Unsure Insurance company ____________

Address of claims office: ____________

DENTAL HISTORY

Has the patient ever sucked the thumb or finger? ○ Yes ○ No

Does the patient breathe through the mouth more than the nose? ○ Yes ○ No

Has the patient been informed of any missing permanent teeth? ○ Yes ○ No

Has the patient been informed of any extra teeth? ○ Yes ○ No

Have any of the patient's teeth been injured in accidents or falls? ○ Yes ○ No

Has the patient had any severe head or facial injuries? ○ Yes ○ No

Is the patient especially apprehensive toward dental visits? ○ Yes ○ No

Has the patient ever had a jaw joint problem? ○ Yes ○ No

Does the patient's jaw ever get stuck or locked? ○ Yes ○ No

Does the patient's jaw get sore or tired when talking or eating? ○ Yes ○ No

Does the patient notice any of the following?

Hearing Loss ○ Yes ○ No ○ Right ○ Left

Headaches ○ Yes ○ No ○ Right ○ Left

Pain in teeth on arising ○ Yes ○ No ○ Right ○ Left

Neck pain ○ Yes ○ No ○ Right ○ Left

Popping, clicking or grating sounds in the jaw ○ Yes ○ No ○ Right ○ Left

List all drugs/medication patient is currently taking: ____________

____

MEDICAL HISTORY

Check any of the following for which the patient has been treated:

☐ Diabetes ☐ Hepatitis ☐ Hay Fever
☐ Rheumatic Fever ☐ Prolonged Bleeding ☐ Tonsil Removal
☐ Heart Trouble ☐ HIV+ ☐ Adenoid Removal
☐ Anemia ☐ Emotional Problems ☐ Current Pregnancy
☐ Epilepsy ☐ Allergies ☐ Frequent canker sores or fever blisters
☐ Kidney Problems ☐ Asthma
☐ Other serious illnesses

Stuffiness in the ears ○ Yes ○ No ○ Right ○ Left

Ringing in the ears ○ Yes ○ No ○ Right ○ Left

Throbbing in the ears ○ Yes ○ No ○ Right ○ Left

Dizziness ○ Yes ○ No ○ Right ○ Left

Difficult to swallow ○ Yes ○ No ○ Right ○ Left

Does the patient smoke? ○ Yes ○ No

Has the patient ever been injured with a blow to the jaw? ○ Yes ○ No

If yes, what happened to the jaw joint afterward? ____________

____

____

Responsible Party Signature **Date**

Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgment

I have received a copy of this office's Notice of Privacy Practices found at www.smithortho.cc/patients/first-visit/.

____

Printed Patient Name

____

Signature

If signing for a minor child please print your name and relationship below:

____

____

Date

____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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