PLEASE PRINT

GENERAL PATIENT INFORMATION

DATE: _____

NAME: FIRST_____ MIDDLE_____ LAST_____ GENDER: M / F
ADDRESS: _____CITY:_____STATE:_____ ZIP: _____
EMAIL (For Appointment Reminders): _____AGE:_____BIRTHDATE:__/__ /__
HOME PHONE: _____ WORK PHONE: _____CELL PHONE: _____
RESPONSIBLE PARTY: _____ RELATIONSHIP TO PATIENT: _____
ADDRESS FOR STATEMENTS (if different from above):_____
CITY: _____ STATE: _____ZIP:_____
HAS ANY FAMILY MEMBER BEEN A PATIENT HERE? YES NO NAME: _____
HAS ANY FAMILY MEMBER WORN BRACES BEFORE? YES NO WHO WAS THE ORTHODONTIST?
_____
EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

I am interested in a low down payment/extended payment plan and understand that this requires a credit review. I hereby authorize R. Cary Bocklet, DMD, MS to order a credit report.
SIGNATURE (Responsible Party):_____ DATE: _____

DENTIST: _____ PHONE: _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE? Name: _____

HOW MANY WAYS HAVE YOU HEARD ABOUT OUR PRACTICE? ☐Friend Name: _____

☐General Dentist ☐Ortho Patient ☐Website / Internet ☐Insurance Plan ☐Ortho Employee ☐Yellow Pages
☐Your Company ☐Office Sign

IF PATIENT IS AN ADULT

EMPLOYER: _____
ADDRESS: _____
POSITION: _____
PHONE NUMBER: _____
SOCIAL SECURITY #: _____

SPOUSE: _____
EMPLOYER: _____
ADDRESS: _____
PHONE NUMBER: _____
SOCIAL SECURITY #:_____

IF PATIENT IS A CHILD

FATHER: _____
EMPLOYER: _____
POSITION: _____
WORK PHONE NUMBER: _____
SOCIAL SECURITY #: _____

MOTHER: _____
EMPLOYER: _____
POSITION: _____
WORK PHONE NUMBER: _____
SOCIAL SECURITY #: _____

MARITAL STATUS: ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

PRIMARY ORTHODONTIC INSURANCE OR

POLICY HOLDER: _____
BIRTHDATE: _____
EMPLOYER: _____
INSURANCE COMPANY: _____
INSURANCE PHONE: _____
ADDRESS: _____
POLICY / GROUP #:_____
EMPLOYEE ID #: _____

SECONDARY INSURANCE

POLICY HOLDER: _____
BIRTHDATE: _____
EMPLOYER: _____
INSURANCE COMPANY: _____
INSURANCE PHONE: _____
ADDRESS: _____
POLICY / GROUP #:_____
EMPLOYEE ID #:_____

INFORMATION AND PAYMENT AUTHORIZATION RELEASE

I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM AND UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF ORTHODONTIC TREATMENT AND AUTHORIZE PAYMENT DIRECTLY TO **R. Cary Bocklet, DMD, MS** OF THE GROUPINSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

_____

SIGNATURE PATIENT / RESPONSIBLE PARTY **DATE**

NEW PATIENT QUESTIONNAIRE

Name _____ **Date** _____

The following questions are designed to obtain your health history and to help us understand what you want to achieve from orthodontic treatment. We will confirm this information when we present your treatment options.

MY CHIEF CONCERNS ARE: _____

HEALTH INFORMATION:
Does the patient have or has the patient ever had any of the following? *(Please check all that apply.)*

☐High/Low Blood Pressure	☐Diabetes	☐Asthma/Hay Fever	☐Jaundice
☐Rheumatic Fever	☐Venereal Disease	☐Epilepsy	☐Aids/HIV
☐Hepatitis	☐Fainting Spells/Seizures	☐Radiation Therapy	☐Osteoporosis
☐Heart Trouble	☐Arthritis	☐Stomach Ulcer	

☐Yes ☐No Does patient require antibiotics prior to treatment? _____

☐Yes ☐No Is patient in good health?

☐Yes ☐No Has there ever been trauma to patients face/teeth? Explain_____

☐Yes ☐No Is the patient presently under the care of a physician for an illness or disease?
Explain_____

☐Yes ☐No Does the patient have a bleeding tendency or do wounds heal slowly?

☐Yes ☐No Is the patient allergic to nickel, latex or any drugs or medications? List: _____

☐Yes ☐No Is the patient taking any medications? List: _____

Signature: _____

CHECK ALL STATEMENTS BELOW THAT APPLY TO THE PATIENT:

The Teeth

☐ There are spaces between the teeth that I do not like.

☐ The teeth are crooked and overlapping.

☐ The teeth stick out too far.

☐ The mouth seems too small, not enough room for the teeth.

☐ The teeth are erupting in the wrong places.

☐ Not aware of any problems.

The Bite

☐ The bite is comfortable and I can eat what I want with no difficulties.

☐ I feel there is a problem with the bite or I have been told there is a problem.

☐ I have frequent or chronic pain in my jaws, face or head.

☐ My jaws click, pop, or lock when I open my mouth.

☐ I have or have had difficulty in opening and/or closing my jaws.

☐ I clench my teeth during the day or grind my teeth during the night.

The Dentist

☐ I visit the dentist regularly, at least every _____ months.

☐ My last cleaning was in the month of _____.

☐ I have not seen the dentist for over a year. I am due for a cleaning.

☐ It has been _____ years since I had my teeth checked by the dentist.

Dental Problems

☐ I have no dental problems that I am aware of other than misaligned teeth.

☐ I am aware of other dental problems that need attention._____

The Orthodontist

☐ This is my first experience with an orthodontist.

☐ The patient has worn braces before. _____ (year)

☐ I have seen another orthodontist and I would like a second opinion. (Dr. name) _____

What I Expect from Orthodontic Treatment

☐ I want all the teeth straightened and the bite corrected if possible.

☐ I want the upper and lower teeth straightened and aligned.

☐ I only want the upper teeth straightened and aligned.

☐ I only want to find out if any treatment is needed.

Insurance

☐ I have insurance that may pay for a portion of the treatment costs. _____ (provider)

☐ I have no insurance that covers orthodontic treatment.

How Soon Would You Like to Get Started?

☐ I would like to get started as soon as possible if it is determined that treatment is indicated.

☐ I want to meet with the orthodontist to discuss the results of the diagnosis before making a decision.

☐ I want to discuss the findings with my spouse before making a decision to start treatment.

☐ I want to delay treatment as long as possible.

Signature _____**Date:**_____