

PATIENT INFORMATION

Date _____
Patient's name _____
Last First Middle
Address _____
Street City State Zip
Home Phone _____ Birthdate _____ Social Security # _____
If patient is a minor, give parent's or guardian's name _____
Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

Name _____
Last First Middle
Address _____
Street City State Zip
Home phone _____ Work phone _____
Cell/other phone _____ Email address _____
Social Security # _____ Birthdate _____ Relationship to Patient _____
Employer _____ Occupation _____
Second Responsible Party Name _____
Relationship to Patient _____
Employer _____ Occupation _____
Social Security # _____ Birthdate _____ Work Phone _____

DENTAL INSURANCE INFORMATION

Insured's Name _____ **Insured's Social Security #** _____
Insurance Company _____ Group No. _____ Local No. _____
Insurance Co. Address _____ Phone No. _____
Do you have dual coverage? Yes _____ No _____ If yes:
Insured's Name _____ **Insured's Social Security #** _____
Insurance Company _____ Group No. _____ Local No. _____
Insurance Co. Address _____ Phone No. _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____
Complete address _____
Street City State Zip
Phone _____

Receipt of Notice of Privacy Practices: I have been offered a copy of Brinley Orthodontics, LLC's Notice of Privacy Practices. Initials _____

Release of Information: I authorize the release of medical and financial information for the purpose of collection of my account. I also authorize my insurance benefits to be paid directly to my doctor and acknowledge that I am financially responsible for any unpaid balance. Initials _____

Doral (All Kids) card holders only: Have you ever been seen by a Doral orthodontist? _____ If so, what were the results?

Signature (Parent's signature if minor) _____
Updates (date & initial) _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____

Address _____ Phone _____

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _____

Yes No Are you allergic to any medication? _____

Yes No Do you have a history of a major illness? _____

Yes No Have you had any operations? _____

Yes No Have you ever been involved in a serious accident? _____

Yes No Have seen a physician in the last 12 months? Why? _____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia Diabetes Hepatitis/Liver problems Pneumonia

Anemia Dizziness Herpes Prolonged Bleeding

Arthritis Epilepsy High Blood Pressure Radiation/Chemotherapy

Asthma or Hayfever Gastrointestinal Disorders HIV / Aids Rheumatic Fever

Bone Disorders Heart Problems Kidney problems Tuberculosis

Congenital Heart Defect Heart Murmur Nervous Disorders Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

DENTAL HISTORY

General Dentist _____ Date of last visit _____

What concerns you most about your teeth? _____

Yes No Are you presently in any dental pain? _____

Yes No Have you ever experienced any unfavorable reaction to dentistry? _____

Yes No Have you ever lost or chipped any teeth? _____

Yes No Have there been any injuries to face, mouth, or teeth? _____

Yes No Is any part of your mouth sensitive to temperature? Where? _____

Yes No Is any part of your mouth sensitive to pressure? Where? _____

Yes No Do your gums bleed when you brush? _____

Yes No Do you have any type of thumb or tongue habit? _____

Yes No Are you a mouth breather? _____

Yes No Have you ever seen an orthodontist? If yes, who and when? _____

Yes No What is your attitude toward receiving orthodontic treatment? _____

Yes No Has anyone in your family received orthodontic treatment? _____

How did they feel about the result? _____

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____

Yes No Are you aware of your jaw clicking or popping? _____

Yes No Are you aware of clenching your teeth during the day? _____

Yes No Have you ever been told that you grind your teeth? _____

Yes No Do you have "tension" headaches? _____

Yes No Have you ever experienced chronic ringing in your ears? _____

Yes No If the patient is under age 16, height of parents? Mom _____ Dad _____

Yes No Are you aware that some appointments will be during school/work hours? _____

Please list some hobbies or interests _____

Female Patients only:

Yes No Are you pregnant? _____

Yes No Has menstruation started? _____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I authorize Brinley Orthodontics to take radiographs of today and throughout the course of treatment. I ensure that the patient is not pregnant, and if were to become pregnant, would notify Brinley Orthodontics immediately. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Christine Brinley to perform a complete orthodontic evaluation.

Signature: _____ Date: _____