Carter Orthodontic Solutions

Patient Information

Male ☐ Female ☐

Name _____ (Last) _____ (First) _____ (Preferred Name) _____ (Date of Birth)

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

E-mail _____ School / Employer _____

Home Phone _____ (999-999-9999) Cell/Other _____ (999-999-9999) Work Phone _____ (999-999-9999)

Do you currently see a General Dentist? ☐ Yes ☐ No

If Yes...Dentist Name _____ Physician _____

How did you find out about our practice? Internet ☐ TV ☐ Radio ☐ Friend ☐ Other: _____

If Minor.... Mother's Name: _____ Father's Name: _____

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

What is your chief concern about your teeth? _____

_____

Responsible Party Information (Financial)

Name _____ (Last) _____ (First) _____ (Middle)

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

E-mail _____

Home Phone _____ (999-999-9999) Cell/Other _____ (999-999-9999) Work Phone _____ (999-999-9999)

Employer _____ Relationship to Patient _____

Primary Dental Insurance Information of Policy Holder

DOES THE PATIENT HAVE Primary ORTHODONTIC INSURANCE? ☐ Yes ☐ No

If YES… Complete Primary Insurance Verification Information Below

Insurance Company _____ Insurance Phone# _____ (999-999-9999)

Subscriber's Name _____ Subscriber's DOB _____ (MM-DD-YYYY)

Subscriber's Social Security# _____ (999-99-9999) Must have to verify and file Insurance Subscriber's Employer _____

Is Subscriber's address different from patient? ☐ Yes ☐ No If Yes …Subscriber's COMPLETE Address:

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Secondary Dental Insurance Information of Policy Holder

DOES THE PATIENT HAVE Secondary ORTHODONTIC INSURANCE? ☐ Yes ☐ No

If YES… Complete Secondary Insurance Verification Information Below

Insurance Company _____ Insurance Phone# _____ (999-999-9999)

Subscriber's Name _____ Subscriber's DOB _____ (MM-DD-YYYY)

Subscriber's Social Security# _____ (999-99-9999) Must have to verify and file Insurance Subscriber's Employer _____

Is Subscriber's address different from patient? ☐ Yes ☐ No If Yes …Subscriber's COMPLETE Address:

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Medical History

Is the patient in good health: ☐ Yes ☐ No if no, please explain. _____

Any major or unusual illness: ☐ Yes ☐ No if so, please explain. _____

Being treated by physician? ☐ Yes ☐ No if so, please explain. _____

Is Patient allergic to Latex : ☐ Yes ☐ No

List all Drugs that the Patient is allergic to:

List all drugs that the Patient is currently taking

Has the patient ever had any of the following medical problems?

Yes	No		Yes	No		Yes	No	
☐	☐	ANEMIA	☐	☐	SCARLET FEVER	☐	☐	HEART PROBLEMS
☐	☐	BLOOD DISEASE	☐	☐	HEPATITIS	☐	☐	TUBERCULOSIS
☐	☐	PROLONGED BLEEDING	☐	☐	GLAUCOMA	☐	☐	DIABETES
☐	☐	JAUNDICE	☐	☐	TONSILITIS	☐	☐	ENDOCRINE PROBLEM
☐	☐	RHEUMATIC FEVER	☐	☐	ADENITIS	☐	☐	BONE DISORDERS
☐	☐	EPILEPSY	☐	☐	HEPATITIS	☐	☐	COLD SORES
☐	☐	ASTHMA	☐	☐	FREQUENT COLD/FLU			

Has the patient tonsils been removed? ☐ Yes ☐ No If yes...then what age? _____

Has the patient adenoids been removed? ☐ Yes ☐ No If yes...then what age? _____

Does the patient breathe though the mouth? ☐ Yes ☐ No If yes... ☐ while Awake? ☐ while Asleep?

Is the patient in a risk group for AIDS? ☐ Yes ☐ No

Has the patient had any severe head or face injuries: ☐ Yes ☐ No

Explain: _____

Has the patient had a history of thumb/finger sucking? ☐ Yes ☐ No Stopped Habit? ☐ Yes ☐ No If yes...then what age? _____

Does the Patient play any musical (wind) instruments? ☐ Yes ☐ No

Which Instrument: _____

Has the patient ever consulted an orthodontist previously? ☐ Yes ☐ No

Has the patient had any previous orthodontic treatment? ☐ Yes ☐ No

Have any family members had orthodontic treatment? ☐ Yes ☐ No

Family Members Treated by Dr. David _____

Please Check If There is any History of:

☐ Joint Popping ☐ Jaw Joint Soreness ☐ Headaches (more than normal)

☐ Clenching/Grinding Teeth ☐ Ringing in the Ears ☐ Jaw Joint Clicking ☐ Soreness (around head/neck/jaw)

Is there any other information that may be helpful? _____

EMERGENCY INFORMATION

Name _____ (Last) _____ (First) _____ (Middle)

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Home Phone _____ (999-999-9999) Cell/Other _____ (999-999-9999) Work Phone _____ (999-999-9999)

Relationship to Patient _____

Please Submit this form and we will have you sign and date this form at your next office visit.

SUBMIT