

Welcome

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SPECIALIST IN ORTHODONTICS
DROCONOR.COM



1

Patient Information

Today's Date: _____ Home Phone: _____
Name: _____ Cell Phone: _____
Birthdate: _____ Age _____ Nickname: _____ Male Female
Address: _____ How did you hear about our office? _____
City/State/Zip: _____
Email Address: _____ Family Dentist: _____
Employer: _____
Employer Address: _____
City/Zip: _____ SS #: _____

2

Primary Orthodontic Insurance

Orthodontic Coverage Yes No

Secondary Orthodontic Insurance

Orthodontic Coverage Yes No

Group # (Plan, Local, or Policy #): _____	Group # (Plan, Local, or Policy #): _____
Policy Owner's Name: _____	Policy Owner's Name: _____
Relationship to Patient: _____	Relationship to Patient: _____
Policy Owner's Birthdate: _____	Policy Owner's Birthdate: _____
SS #: _____	SS #: _____
Policy Owner's Employer: _____	Policy Owner's Employer: _____
Insurance Co. Name: _____	Insurance Co. Name: _____
Insurance Co. Address: _____	Insurance Co. Address: _____
Insurance Co. Phone #: _____	Insurance Co. Phone #: _____
Signature on file for insurance claims _____	Signature on file for insurance claims _____

3 Were you referred by your dentist? Yes No
What do you dislike about your teeth?

4 Have you had any of the following dental problems?

- Y N Orthodontic Evaluation or Treatment
- Y N Periodontal Treatment (Gum Disease)
- Y N TMJ Treatment (Jaw Joint)
- Y N Grinding Your Teeth
- Y N Sounds in Your Jaw
- Y N Jaw Pain When Opening or Closing
- Y N Injuries to the Face, Head, Teeth
- Y N Mouth Breathing
- Y N Removal of Tonsils or Adenoids
- Y N Sores or Lumps in Your Mouth
- Y N Speech Problems
- Y N Thumb or Finger Sucking

Are you allergic to any drugs or other substances?

Other: _____

5 Have you had any of the following medical problems?

- Y N Abnormal Bleeding
- Y N Allergic to any Drugs
- Y N Allergic to Latex/Metals
- Y N Allergic to Plastic
- Y N Any Hospital Stays
- Y N Any Operations
- Y N Asthma
- Y N Cancer
- Y N Congenital Heart Defect
- Y N Convulsions/Epilepsy
- Y N Diabetes
- Y N Handicaps/Disabilities
- Y N Hearing Impairment
- Y N Heart Murmur
- Y N Hepatitis
- Y N Hemophilia
- Y N HIV+/AIDS
- Y N Kidney/Liver Problems
- Y N Rheumatic/Scarlet Fever
- Y N Tuberculosis

Plases discuss any other medical problems:

List drugs currently taking: _____

6 I understand the following information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in medical status. I authorize the dental staff to perform the necessary dental services. I have received a copy of this office's Notice of Privacy Practices.

Signature _____

Date _____

Summary (for office use only)