



**ORTHODONTIC INSURANCE INFORMATION (CONFIDENTIAL)**

**PATIENT NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

Yes No Does the patient have Orthodontic Coverage?

Yes No Does the patient have Dental Coverage?

**Primary Orthodontic Coverage**

Insurance Company's Name: \_\_\_\_\_

Insurance Company's Address: \_\_\_\_\_

Insurance Company's Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Relation to Patient: \_\_\_\_\_

Insured's SS#: \_\_\_\_\_ Patient's SS#: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

**Secondary Orthodontic Coverage**

Insurance Company's Name: \_\_\_\_\_

Insurance Company's Address: \_\_\_\_\_

Insurance Company's Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Relation to Patient: \_\_\_\_\_

Insured's SS#: \_\_\_\_\_ Patient's SS#: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

**MEDICAL INFORMATION**

Physician: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Address: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Now or in the past, has the patient had?

- |                                     |                                    |  |  |                                     |                                    |  |                               |
|-------------------------------------|------------------------------------|--|--|-------------------------------------|------------------------------------|--|-------------------------------|
| <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> | <input type="checkbox"/> <b>Unsure</b> | AIDS or HIV positive?                        | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> | <input type="checkbox"/> <b>Unsure</b> | Fainting spells?              |
| <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> | <input type="checkbox"/> <b>Unsure</b> | Anemia?                                      | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> | <input type="checkbox"/> <b>Unsure</b> | Gastrointestinal disorders?   |
| <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> | <input type="checkbox"/> <b>Unsure</b> | Arthritis?                                   | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> | <input type="checkbox"/> <b>Unsure</b> | Headaches?                    |
| <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> | <input type="checkbox"/> <b>Unsure</b> | Asthma?                                      | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> | <input type="checkbox"/> <b>Unsure</b> | Hepatitis?                    |
| <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> | <input type="checkbox"/> <b>Unsure</b> | Birth defects or hereditary problems?        | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> | <input type="checkbox"/> <b>Unsure</b> | Herpes?                       |
| <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> | <input type="checkbox"/> <b>Unsure</b> | Behavioral, Emotional or Learning disorders? | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> | <input type="checkbox"/> <b>Unsure</b> | Heart trouble?                |
| <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> | <input type="checkbox"/> <b>Unsure</b> | Bleeding disorders?                          | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> | <input type="checkbox"/> <b>Unsure</b> | High blood pressure?          |
| <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> | <input type="checkbox"/> <b>Unsure</b> | Bone disorders?                              | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> | <input type="checkbox"/> <b>Unsure</b> | Immune disorders?             |
| <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> | <input type="checkbox"/> <b>Unsure</b> | Bone fractures?                              | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> | <input type="checkbox"/> <b>Unsure</b> | Kidney disorders?             |
| <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> | <input type="checkbox"/> <b>Unsure</b> | Cancer or tumors?                            | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> | <input type="checkbox"/> <b>Unsure</b> | Liver disorders?              |
| <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> | <input type="checkbox"/> <b>Unsure</b> | Diabetes?                                    | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> | <input type="checkbox"/> <b>Unsure</b> | Muscle disorders?             |
| <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> | <input type="checkbox"/> <b>Unsure</b> | Dizziness?                                   | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> | <input type="checkbox"/> <b>Unsure</b> | Nervous disorders?            |
| <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> | <input type="checkbox"/> <b>Unsure</b> | Eating disorders?                            | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> | <input type="checkbox"/> <b>Unsure</b> | Rheumatic Fever?              |
| <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> | <input type="checkbox"/> <b>Unsure</b> | Endocrine disorders?                         | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> | <input type="checkbox"/> <b>Unsure</b> | Tonsil or Adenoid conditions? |
| <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> | <input type="checkbox"/> <b>Unsure</b> | Epilepsy?                                    | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> | <input type="checkbox"/> <b>Unsure</b> | Tuberculosis?                 |

Allergies or reactions to any of the following:

- |                                     |                                    |  |                                |                                     |                                    |  |  |
|-------------------------------------|------------------------------------|--|--------------------------------|-------------------------------------|------------------------------------|--|--|
| <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> | <input type="checkbox"/> <b>Unsure</b> | Ibuprofen                      | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> | <input type="checkbox"/> <b>Unsure</b> | Metals (jewelry snaps)?                |
| <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> | <input type="checkbox"/> <b>Unsure</b> | Latex (e.g., balloons, gloves) | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> | <input type="checkbox"/> <b>Unsure</b> | Foods or flavorings?<br>Specify: _____ |
| <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> | <input type="checkbox"/> <b>Unsure</b> | Vinyl                          | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> | <input type="checkbox"/> <b>Unsure</b> | Other: _____                           |
| <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> | <input type="checkbox"/> <b>Unsure</b> | Acrylic                        |                                     |                                    |  |  |

Medications:

**Yes**  **No**  **Unsure** Is the patient taking medication, nutrient supplements, herbal medications or nonprescription medicine? Please name them and what they are taken for:

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Women and Girls only:

Yes No Unsure Has the patient started her monthly periods? Approximately when? \_\_\_\_\_

Yes No Unsure Is the patient pregnant?

Are there any major illnesses or medical conditions not mentioned above that we should be aware of?  
\_\_\_\_\_

**DENTAL INFORMATION**

Dentist: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Date of last visit: \_\_\_\_\_ Frequency of visits: \_\_\_\_\_

How many times a day does the patient brush their teeth? \_\_\_\_\_ Floss their teeth? \_\_\_\_\_

Now or in the past, has the patient had?

- Yes No Unsure Prior orthodontic examination or treatment?
- Yes No Unsure Started teething very early or late?
- Yes No Unsure Teeth sensitive to hot or cold?
- Yes No Unsure Chipped or injured baby or permanent teeth?
- Yes No Unsure Jaw fractures or other trauma to the neck, head and jaw area?
- Yes No Unsure Tooth grinding and/or jaw clenching?
- Yes No Unsure Jaw popping and/or clicking?
- Yes No Unsure Pain in jaw when chewing or ringing in ear?
- Yes No Unsure Pain or soreness in the muscles of the face or around the ears?
- Yes No Unsure Chronic neck pain?
- Yes No Unsure Difficulty encountered in chewing or jaw opening?
- Yes No Unsure History of speech problems? Been under the care of a speech therapist?
- Yes No Unsure Mouth breathing habit?
- Yes No Unsure Snoring or difficulty breathing?
- Yes No Unsure Abnormal swallowing habit (tongue thrusting)?
- Yes No Unsure Thumb, finger or lip sucking habit? Until what age? \_\_\_\_\_
- Yes No Unsure Frequent cancer sores or cold sores?
- Yes No Unsure Gums bleed when brushed or flossed?
- Yes No Unsure Wisdom teeth extracted?
- Yes No Unsure Extra or missing teeth from birth?
- Yes No Unsure Periodontal "gum problems"?
- Yes No Unsure Been under the care of a dental specialist? Specialist: \_\_\_\_\_
- Yes No Unsure Taking any forms of fluoride?
- Yes No Unsure Any serious trouble associated with previous dental treatment?
- Yes No Unsure Any relative with similar tooth or jaw relationships?

Yes No Unsure Sensitive or self-conscious about teeth?

Are there any dental conditions not mentioned above that you feel we should be aware of?

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I/We certify that the information on this form is true and correct to the best of my/our knowledge, that it will be held in the strictest of confidence, and I/we will notify you of any changes.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_