iowa ORTHODONTIC SOLUTIONS wemakeiowasmile.com

Welcome to our office! Please help us serve your needs by completing this information sheet.

Patient's Name: First _____ MI _____ Last _____ Date _____

Nickname _____ Sex ___M ___F Age _____ Birthdate _____

Address _____ City _____ Zip Code _____

Home Phone _____ Patient Cell Phone _____

Patient E-Mail _____ School _____

Patient's Dentist _____ Last Dental Visit _____

Whom may we thank for referring you to our office? _____

Have you or any other family members been treated by our office? _____

Reason for seeking orthodontic consultation? _____

Have you ever seen another orthodontist? _____

Who is responsible for the account? _____

Father's Name _____ Home Phone _____

Address _____ City _____ Zip Code _____

Cell Phone _____ E-Mail _____

Employer _____ Work Phone _____

Social Security # _____ Birthdate _____

Do you have orthodontic insurance? ____ If yes, we will need a copy of your INSURANCE CARD.

INS Company Name _____ Phone _____

Mother's Name _____ Home Phone _____

Address _____ City _____ Zip Code _____

Cell Phone _____ E-Mail _____

Employer _____ Work Phone _____

Social Security # _____ Birthdate _____

Do you have orthodontic insurance? ____ If yes, we will need a copy of your INSURANCE CARD.

INS Company Name _____ Phone _____

If your insurance or any information changes, you will need to notify the office.

PLEASE continue on the back of this page.

Members American Association of Orthodontists

MEDICAL HISTORY

Physician _____

Address _____ Phone _____

Please circle YES or NO (if Yes, please fill in details)

YES NO Is the patient presently taking any medication? _____
YES NO Is the patient allergic to any medication? _____
YES NO History of a major illness? _____
YES NO Has the patient had any operations? _____
YES NO Ever been involved in a serious accident? _____
YES NO Have seen a physician in the last 12 months? Why ? _____
YES NO Is the patient pregnant? _____

Circle any of the medical conditions below that the patient has had or currently has:

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hay fever	Gastrointestinal Disorders	HIV/Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney Problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorder	Tumor or Cancer

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

_____

Allergy to Nickel or Latex? _____

DENTAL HISTORY

Please circle YES or NO (if Yes, please fill in details)

YES NO Is the patient presently in any dental pain? _____
YES NO Has the patient 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 gums bleed when brushing ? _____
YES NO Any type of thumb or tongue habit? _____
YES NO Smoke or use tobacco? _____
YES NO Nail biting? _____
YES NO Lip/Tongue biting? _____
YES NO Play musical instrument? _____
YES NO Is the patient a mouth breather? _____
YES NO Has anyone in the family received orthodontic treatment? _____
YES NO Do teeth or jaws ever feel uncomfortable first thing in the morning? _____
YES NO Experience jaw clicking or popping? _____
YES NO Aware of clenching or grinding teeth during the day? _____
YES NO Experience "tension" headaches? _____
YES NO Does the patient need extra help with instructions? _____
YES NO Is the patient sensitive or self-conscious about his/her teeth? _____
YES NO Are you aware that some appointments will be during school hours? _____

I affirm this information to be accurate, and I will inform Iowa Orthodontic Solutions of any change(s) in my medications or health status at the beginning of each appointment. My dental insurance company (if applicable) has my permission to pay benefits directly to Iowa Orthodontic Solutions for services they have performed, although ultimate responsibility for payment of the account is mine.

_____ _____

Signature (parent's signature if patient is a minor) Date