



WELCOME

Stephen J. Harper D.D.S.

ORTHODONTIST

General Information

Today's Date: _____
Mr. Mrs. Ms. Dr.
Name:(L) _____ (F) _____
I prefer to be called: _____
Birthdate: __/__/____ Age: _____ Male () Female ()
E-mail Address: _____@_____.com
SS#: _____ DL #: _____
Home Address: _____

State: _____ City: _____ Zip: _____
() Single () Married () Divorced () Widowed () Separated
Home #: () _____ Cell #: () _____
Wk #: () _____ EXT: _____
Employer: _____
Employer's Address: _____
State: _____ City: _____ Zip: _____
How long there? _____ Occupation: _____
When & Where are the best times to reach you? _____
Whom may we thank for referring you? _____
Other family members seen by us: _____

Previous/Present Dentist: _____
Dentist Phone #: () _____
Last Visit date: _____

Spouse Information

His/Her Name: _____
Employer: _____ Occupation: _____
Wk #:() _____ Ext: _____ Cell #:() _____
Birth date: __/__/____ Age: _____ SS# _____

Relative or friend not living with you
Name: _____ Relation: _____
Wk#:() _____ EXT: _____ Home #:() _____

Insurance

Orthodontic coverage () Yes () No
Primary
Insurance Co. Name: _____
Insurance Address: _____
State: _____ City: _____ Zip _____
Insurance Phone:() _____
Group#(plan, local, or policy#) _____
Insured Name: _____ Relation: _____
Insured DOB: __/__/____ Insured SS#: _____
Insured's Employer: _____
Insured's Employer's Address: _____
City: _____ State: _____ Zip: _____

Orthodontic Coverage () Yes () No
Secondary
Insurance Co. Name: _____
Insurance Address: _____
State: _____ City: _____ Zip _____
Insurance Phone:() _____
Group#(plan, local, or policy#) _____
Insured Name: _____ Relation: _____
Insured DOB: __/__/____ Insured SS#: _____
Insured's Employer: _____
Insured's Employer's Address: _____
City: _____ State: _____ Zip: _____

Authorization

This office reserves the right to verify the credit status of potential patients and/or parents prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. If this office accepts insurance, I understand that I am responsible for the payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize the Dr. Stephen Harper to release all information necessary to secure the payment of benefits. And I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature _____ Date _____

Dental & Medical History

What are the main concerns that you would like orthodontics to accomplish? _____

Have you ever been evaluated for orthodontic treatment before? Yes No

Have there ever been any injuries to the face, mouth, teeth, or chin? Yes No

Do you require antibiotics before dental treatment? Yes No

Have adenoids or tonsils been removed? Yes No

Do you have any missing or extra permanent teeth? Yes No

Have you ever had any pain/tenderness in your jaw joint? (TMJ/TMD)? Yes No

Do you still have your wisdom teeth? Yes No

Do you have any speech problems? Yes No

Please describe your current physical health: Good Fair Poor

Please describe your current dental health: Good Fair Poor

Are you happy with your smile: Yes No

Physician: _____ Phone #: _____

Are you currently under the care of a physician? Yes No

Please list all the drugs you are currently taking: _____

Aside from item listed below, list all drugs/ things you are allergic to: _____

Latex: Yes No Nickel/Metals: Yes No Plastic: Yes No Milk: Yes No

Our office is HIPPA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in strictest confidence and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental/orthodontic services my child may need.

Signature

_____/_____/_____
Date

Have you experienced the following diseases or medical problems?

Y N Abnormal Bleeding Y N Heart Impairments

Y N ADD/ ADHD Y N Heart Murmur

Y N AIDS/HIV+ Y N Hemophilia

Y N Any hospital stays/Operations Y N Hepatitis

Y N Artificial Bones/Joints/Valves Y N Kidney Problems

Y N Asthma Y N Liver Problems

Y N Cancer Y N MVP

Y N Congenital heart defect Y N Prosthetics

Y N Convulsions Y N Rheumatic Fever

Y N Diabetes Y N Scarlet Fever

Y N Epilepsy Y N Sickle Cell

Y N Handicaps/Disabilities Y N Sinus Problems

Y N Herpes/Fever blisters Y N Tuberculosis

Y N Alcohol/drug abuse Y N Seizures

Y N Frequent Headaches Y N Fainting spells

Please list any serious medical condition(s) that you have or ever had: _____

Are you currently under the care of a physician?
Yes No

Do you generally breathe through your mouth? Y N

While awake? Y N

While asleep? Y N

FOR WOMEN:

Are you pregnant? Yes No Weeks#: _____

Are you taking birth control pills? Yes No

Are you nursing? Yes No

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I have verbally reviewed the medical/dental information above with patient named herein:

Signature of Dentist Date

Dentist's comments: _____

