Welcome to Fischer Family Orthodontics

Name_____

Date of Birth _____/_____/_____ Age _____ ◯ Male ◯ Female ◯ Unspecified

Address_____
Street City State Zip Code

Telephone Number _____

◯ Single ◯ Married ◯ Partnered ◯ Widowed ◯ Divorced ◯ Separated

Employer_____

Employer's Address_____

Whom may we thank for referring you?_____

Other family members seen by us_____

General Dentist _____ Last visited_____

Spouse/Partner Information

Name_____ Date of Birth_____

Telephone Number_____

Employer_____

If you have Orthodontic Insurance, please fill out below:
Policyholder Name_____

Insurance Company Name_____

Insurance Company Telephone Number_____

Subscriber ID#_____

This office reserves the right to verify the credit status of potential patients and/or parents of patients 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 payment of services rendered and also responsible for paying any co-payment and deductibles that my insurances does not cover. I hereby authorize the dentist 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

Do you have a personal physician? ◯ Yes ◯ No Last visited_____
Physician's Name_____ Telephone_____

Your current physical health is ◯ Good ◯ Fair ◯ Poor

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

Are you taking any prescription/over-the-counter drugs? ◯ Yes ◯No
Please list each one_____
_____

For Women: Are you using a prescribed method of birth control? ◯ Yes ◯No
Are you pregnant? ◯ Yes ◯No Are you nursing? ◯ Yes ◯No

Have you ever had any of the following diseases or medical problems?

Y / N Abnormal Bleeding	Y / N Epilepsy / Seizures / Fainting	Y / N Mitral Valve Prolapse
Y / N Anemia	Y / N Fever Blisters/Herpes	Y / N Psychiatric Problems
Y / N Artificial Bones/Joints/Valves	Y / N Glaucoma	Y / N Radiation Treatment
Y / N Asthma	Y / N Heart Attack / Stroke	Y / N Rheumatic/Scarlet Fever
Y / N Arthritis	Y / N Heart Murmur	Y / N Severe/Frequent Headaches
Y / N Blood Transfusion	Y / N Heart Surgery / Pacemaker	
Y / N Cancer / Chemotherapy	Y / N Hemophilia	Y / N Shingles
Y / N Congenital Heart Defect	Y / N Hepatitis	Y / N Sickle Cell Disease/Traits
Y / N Diabetes	Y / N High/Low Blood Pressure	Y / N Sinus Problems
Y / N Difficulty Breathing	Y / N HIV+ / AIDS	Y / N Tuberculosis (TB)
Y / N Drug / Alcohol Abuse	Y / N Hospitalized for Any Reason	Y / N Ulcers/Colitis
Y / N Emphysema	Y / N Kidney Problems	Y / N Venereal Disease

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

Are you allergic to any of the following:

Y / N Aspirin	Y / N Dental Anesthetics	Y / N Penicillin
Y / N Any Metals/Plastics	Y / N Erythromycin	Y / N Tetracycline
Y / N Codeine	Y / N Latex	

Y / N Other (Please lists any other drugs/materials you are allergic to:_____
_____

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

Have you ever had or been evaluated for orthodontic treatment? ◯ Yes ◯No

Have you ever had a serious / difficult problem associated with any previous dental work? ◯ Yes ◯No

Do you now or have you ever experienced pain / discomfort in your jaw Joint (TMJ / TMD)? ◯ Yes ◯No

Your current dental health is ◯ Good ◯ Fair ◯ Poor

Do you like your smile? ◯ Yes ◯No Gums bleed? ◯ Yes ◯No

Have you ever had an injury to your Mouth Teeth Chin (Please Circle)

Do you have any speech problems?_____

Do you generally breathe through your mouth? ◯ Yes ◯No
If yes, please circle: While Awake? While Asleep?

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

Have you ever taken Fosamax, or any other bisphosphonate? ◯ Yes ◯No

Have you ever taken Phen-Fen? ◯ Yes ◯No

Do you smoke or use tobacco in any form? ◯ Yes ◯No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature Date

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office.

_____

Signature Date

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

_____

FOR OFFICE USE ONLY - FOR OFFICE USE ONLY - FOR OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials_____ Date:_____

Doctor's Comments:_____
_____
_____
_____