BRIAN W PAYNE DDS

orthodontic specialist for adults & children

THE BENEFITS OF A HAPPY, HEALTHY SMILE ARE IMMEASURABLE! OUR GOAL IS TO HELP YOU REACH AND MAINTAIN A HEALTHY AND PLEASING BITE. PLEASE FILL OUT THESE FORMS COMPLETELY, THE BETTER WE COMMUNICATE, THE BETTER WE CAN CARE FOR YOU.

1. ABOUT YOU

TODAY'S DATE: _____
MONTH DAY YEAR

NAME:

_____
LAST FIRST MIDDLE INITIAL

I LIKE TO BE CALLED: _____

HOME ADDRESS: _____
APT/CONDO #

_____
CITY STATE ZIP CODE

MAILING ADDRESS, IF DIFFERENT:

ADDRESS: _____

_____
CITY STATE ZIP CODE

YOUR EMPLOYER: _____

OCCUPATION: _____

SOCIAL SECURITY #: _____

_____

BIRTHDAY: __/__/__ ☐ MALE ☐ FEMALE

☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

SPECIAL INTEREST, HOBBIES OR SPORTS: _____

REFERRED BY: _____

GENERAL DENTIST: _____ LAST VISIT: __/__/__

2. DENTAL INSURANCE

DO YOU HAVE DENTAL INSURANCE THROUGH YOUR EMPLOYER? ☐ YES ☐ NO
DOES YOUR DENTAL INSURANCE HAVE ORTHODONTIC BENEFITS? ☐ YES ☐ NO
IF YES, PLEASE PROVIDE THE FOLLOWING INFORMATION:

DENTAL INSURANCE CO. #1: _____

GROUP #: _____

INSURANCE CO. PHONE #: _____

YOUR EMPLOYER'S NAME: _____

DO YOU HAVE ANY OTHER DENTAL INSURANCE COVERAGE? ☐ YES ☐ NO

THIS COVERAGE IS THROUGH: ☐ SPOUSE ☐ PARENT ☐ OTHER: _____

THEIR NAME: _____

THEIR EMPLOYER'S NAME: _____

THEIR SOCIAL SECURITY #: _____

THEIR BIRTHDATE: __/__/__
MONTH DAY YEAR

DENTAL INSURANCE CO. #2: _____

GROUP #: _____

INSURANCE CO. PHONE #: _____

☎ HOME PHONE: _____ WORK PHONE: _____

WHEN IS THE BEST TIME TO REACH YOU? _____

WHERE? _____ SPECIFIC DAYS? _____

3. Medical History

Do you have a personal physician? ☐ Yes ☐ No

Their Name: _____ Their Phone No.: _____

The approximate date of your last visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of any physician? ☐ Yes ☐ No

If yes, please explain: _____

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

Are you presently taking any drugs prescribed by a physician or dentist?
☐ Yes ☐ No
If Yes, please list: _____

_____

For Women: Are you pregnant? ☐ No ☐ Yes, Week. # _____

Do you need to be premedicated before dental treatment?
☐ *Yes* ☐ *No*

Have you had any serious medical problems in the last 5 years?
☐ Yes ☐ No If yes, please explain: _____

_____

Have you ever been diagnosed or treated for any of the following?

Yes	No		Yes	No	
☐	☐	Heart Attack/Stroke	☐	☐	Cancer/Chemotherapy
☐	☐	Heart Murmur/Rheumatic Fever	☐	☐	HIV+/AIDS
☐	☐	Heart Surgery/Pacemaker	☐	☐	Shingles
☐	☐	Chronic Hepatitis	☐	☐	Kidney Problems
☐	☐	Anemia	☐	☐	Sinus Problems
☐	☐	High/Low Blood Pressure	☐	☐	Fever Blisters
☐	☐	Severe Headaches	☐	☐	Psychiatric problems
☐	☐	Epilepsy/Seizures/Fainting	☐	☐	Diabetes
☐	☐	Drug/Alcohol Abuse	☐	☐	Tuberculosis (TB)
☐	☐	Hemophilia/Abnormal Bleeding	☐	☐	Sickle Cell Disease
☐	☐	Asthma	☐	☐	Arthritis
☐	☐	Tonsils Removed	☐	☐	Adenoids Removed

Any other serious medical conditions:
Have you experienced any that are not listed above? ☐ Yes ☐ No

If yes, please explain? _____

Are you allergic to any of the following?

Y	N		Y	N	
☐	☐	Penicillin	☐	☐	Aspirin
☐	☐	Erythromycin	☐	☐	Tetracycline
☐	☐	Dental Anesthetics	☐	☐	Codeine

Are you allergic to any other drugs? ☐ *Yes* ☐ *No*

If yes, please list: _____

Our office is committed to meeting or exceeding the standards ofinfection control mandated by OSHA, CDC and the ADA.

A credit report may be used in order to offer flexible payment schedules.

4. Dental History

Do you breathe predominantly through the mouth?
☐ Yes ☐ No

Do you clench or grind teeth (at Night) (Day)?
☐ Yes ☐ No

Have you experienced TMJ problems?
☐ Yes ☐ No
(TMJ is pain or discomfort in your jaw joint)

Have you had any severe head or face injuries?
☐ Yes ☐ No When? _____

Have any teeth been chipped or injured?
☐ Yes ☐ No When? _____

Any noticeable difficulty in chewing or swallowing food?
☐ Yes ☐ No

Have you been informed of extra or missing teeth?
☐ Yes ☐ No

Have any teeth been removed by extraction?
☐ Yes ☐ No Why? _____

Has any member of the family had orthodontic treatment?
☐ Yes ☐ No If yes, who? _____

Have you had any previous orthodontic consultation or treatment?
☐ Yes ☐ No

Are you concerned about the appearance of your teeth?
☐ Yes ☐ No

Do you want your teeth straightened?
☐ Yes ☐ No

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

_____

_____

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.

_____
Signature Date

! Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

SUBMIT