Welcome to

coleman
ORTHODONTICS

Thank you for choosing Coleman Orthodontics! We strive to provide you with the best orthodontic care possible. To help us meet your needs, please fill out this form completely in ink. If you have questions or need assistance, please ask us—we will be happy to help.

Patient # _____

SS#/SIN _____

Date _____

Patient Information (*Confidential*)

Name _____ Birth date _____ Phone _____

Address _____ City _____ State _____ Zip _____

E-Mail _____ Cell Phone _____

Check Appropriate Box: ❑Minor ❑Single ❑Married ❑Divorced ❑Widowed ❑Separated ~~~~ ❑**Male** ❑**Female**

If Student, Name of School / College _____ Grade _____

Who may we thank for referring you? _____

Responsible Party

Patient lives with: ❑ Mom ❑ Dad ❑ Spouse ❑ Other

If Other, who: _____ Relationship

Name of person responsible for this account _____ to patient _____

Address _____ Home Phone _____

E-Mail _____ Cell Phone _____

Driver's License # _____ Birth date _____ Financial Institution _____

Employer _____ Work Phone _____ SS# _____

For your convenience, we offer the following methods of payment. Please check the option you prefer.

❑Cash ❑Personal Check Credit Card ❑Visa ❑MasterCard ❑I wish to discuss the office's payment policy

Emergency Contact Information

Dad's Name _____

Dad's Contact Number _____

Mom's Name _____

Mom's Contact Number _____

Parents are: (check one) ❑ Married ❑ Divorced

Patient Spouse's Name _____

Spouse's Contact Number _____

Emergency Contact Other than Parent:

_____

Relationship to Patient _____

Contact Number _____

Insurance Information - Dental

Name of Insured _____ Relationship To patient _____

Birth date _____ SS# _____ Date Employed _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____ Phone _____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? ❑Yes ❑No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship To patient _____

Birth date _____ SS# _____ Date Employed _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____ Phone _____

◆ *Over Please* ◆

Patient Medical History

Physician _____ Office Phone _____ Date of last exam_____

		Yes	No
1.	Are you under medical treatment now?.....	❑	❑
2.	Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain. _____ _____	❑	❑
3.	Are you taking any medication(s) including non-prescription medicine?..... If yes, what medication(s) are you taking?_____ _____	❑	❑
4.	Have you ever taken Fen-Phen? Redux?	❑	❑
5.	Do you use tobacco?.....	❑	❑
6.	Do you use controlled substances?.....	❑	❑
7.	Are you wearing contact lenses?.....	❑	❑
8.	Do you have a persistent cough or throat clearing not associated with an illness (Lasting over 3 weeks)?	❑	❑

		Yes	No
9.	Are you allergic to or have had any reactions to the following?		
	Latex Rubber	❑	❑
	Any Metals (e.g. nickel, mercury, etc.)	❑	❑
	Local Anesthetics (e.g. Novocain)	❑	❑
	Penicillin or any other Antibiotics	❑	❑
	Sulfa Drugs	❑	❑
	Barbiturates	❑	❑
	Sedatives	❑	❑
	Iodine	❑	❑
	Aspirin	❑	❑
	Other (please list) _____	❑	❑
10.	Women only:		
	A) Are you pregnant or think you may be pregnant?	❑	❑
	B) Are you nursing?	❑	❑
	C) Are you taking oral contraceptives?	❑	❑

Do you have or have you had any of the following?

	Y	N		Y	N		Y	N
Heart Attack	❑	❑	Heart Disease	❑	❑	Mitral Valve Prolapse	❑	❑
High Blood Pressure	❑	❑	Cardiac Pacemaker	❑	❑	Heart Trouble	❑	❑
Rheumatic Fever	❑	❑	Angina	❑	❑	Heart Murmur	❑	❑
Swollen Ankles	❑	❑	Frequently Tired	❑	❑	Chest Pains	❑	❑
Fainting / Seizures	❑	❑	Anemia	❑	❑	Easily Winded	❑	❑
Asthma	❑	❑	Emphysema	❑	❑	Stroke	❑	❑
Low Blood Pressure	❑	❑	Cancer	❑	❑	Hay fever / Allergies	❑	❑
Epilepsy / Convulsions	❑	❑	Arthritis	❑	❑	Tuberculosis	❑	❑
Leukemia	❑	❑	Joint Replacement or Implant	❑	❑	Radiation Therapy	❑	❑
Diabetes	❑	❑	Hepatitis / Jaundice	❑	❑	Glaucoma	❑	❑
Kidney Diseases	❑	❑	Sexually Transmitted Disease	❑	❑	Liver Disease	❑	❑
AIDS or HIV Infection.....	❑	❑	Stomach Trouble / Ulcers	❑	❑	Respiratory Problems	❑	❑
Thyroid Problems	❑	❑	Recent Weight Loss	❑	❑	Other	❑	❑

Patient Dental History

Your Regular Dentist Name _____ Date of last check-up_____

		Y	N
1.	Do your gums bleed while brushing or flossing?.....	❑	❑
2.	Are your teeth sensitive to hot or cold liquids?.....	❑	❑
3.	Are your teeth sensitive to sweet or sour foods/liquids?	❑	❑
4.	Do you feel pain in any of your teeth?	❑	❑
5.	Do you have any sores or lumps in/near your mouth?	❑	❑
6.	Have you had any head, neck or jaw injuries?	❑	❑
7.	Have you ever experienced any of the following problems in your jaw?		
	Clicking	❑	❑
	Pain (joint, ear, side of face).....	❑	❑
	Difficulty in opening or closing	❑	❑
	Difficulty in chewing	❑	❑

		Y	N
8.	Do you have frequent headaches?	❑	❑
9.	Do you clench or grind your teeth?	❑	❑
10.	Do you bite your lips or cheeks frequently?	❑	❑
11.	Have you ever had a difficult extraction?	❑	❑
12.	Have you ever had prolonged bleeding after an extraction?	❑	❑
13.	Have you ever had orthodontic treatment?..... If so, when & how long?_____	❑	❑
14.	Do you wear dentures or partials?	❑	❑
15.	Have you ever received oral hygiene instruction?	❑	❑
16.	Do you like your smile?.....	❑	❑

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to the patient's health. I authorize the orthodontist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Orthodontic care to third party payers and/or health practitioners. I hereby authorize Coleman Orthodontics to send correspondence and/or x-rays to any requested Dental Provider via USPS or via common unencrypted e-mail server as needed. No personal or financial information will be released. I authorize and request my insurance company to pay directly to the orthodontist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents incurred at the initial exam including any x-rays.

X_____ _____

Signature of patient (or parent/guardian if minor) DATE