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 ☐

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I have verbally reviewed the medical/dental information above with patient named herein:
_____
Signature of Dentist Date

Dentist's comments: _____
_____
_____