Dr. P. Mike Upton

WELCOME TO THE ORTHODONTIST

The benefits of a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset.

Please fill out these forms completely. The better we communicate, the better we can care for you.

1 About You

Today's Date: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ ❒ Male ❒ Female

Birthdate: ____/____/____ Age: _____ SS#: _____

Home Address: _____
APT/CONDO#

_____
CITY STATE ZIP

❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Separated

Home #: _____ Pager/Other #: _____

WK#: _____ Ext _____ DL#: _____

E-Mail Address: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we **Thank** for referring you? _____

Other family members seen by us: _____

General Dentist: _____

Last Visit Date: _____

2 Spouse Information

His/Her Name: _____

Employer: _____

WK#: _____ Ext _____ SS#: _____

Birthdate: ____/____/____

Person Responsible for Account: _____

WK#: _____ Ext _____ HM#: _____

Billing Address: _____
ZIP

Relationship: _____ SS#: _____

Employer: _____ DL#: _____

Birthdate: ____/____/____

3 Orthodontic Insurance

Primary

Orthodontic Coverage: ❒ No ❒ Yes

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy#): _____

Insured's Name: _____ Relation: _____

Insured's Birthday: ___/___/___ Insured's SS#: _____

Insured's Employer: _____

Secondary

Orthodontic Coverage: ❒ No ❒ Yes

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy#): _____

Insured's Name: _____ Relation: _____

Insured's Birthday: ___/___/___ Insured's SS#: _____

Insured's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

Their Name: _____ Relation: _____

WK#: _____ HM#: _____

4 Medical History

Do you have a personal physician? ❒ No ❒ Yes

Physician's Name: _____

Phone #: _____ Date of last visit: _____

CONTINUED ON BACK OF FORM

4 MEDICAL HISTORY *continued*

Your current physical health is ❒ Good ❒ Fair ❒ Poor

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

Please explain _____

Are you taking any prescription/over-the-counter drugs? ❒ No ❒ Yes

Please list each one _____

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

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

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

_____

Are you allergic to any of the following items?

Y	N	Penicillin	Y	N	Tetracycline	Y	N	Latex
Y	N	Aspirin	Y	N	Dental Anesthetics	Y	N	Any Metal/Plastic
Y	N	Erythromycin	Y	N	Codeine	Y	N	Other

Please list any other drugs that you are allergic to: _____

_____

5 DENTAL HISTORY

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

_____

_____

_____

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

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

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

Your current dental health is ❒ Good ❒ Fair ❒ Poor

Do you like your smile? ❒ No ❒ Yes

Do your gums ever bleed? ❒ No ❒ Yes

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? Y N Awake? Y N Asleep? (Please Circle One)

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

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 with my informed consent that I may need during diagnosis and treatment.

_____

Signature **Date**

! THANK YOU FOR FILLING OUT THIS FORM COMPLETELY.

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.

_____

Signature **Date**

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

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY**

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

Doctor's Comments:

_____

_____

_____