ORTHODONTICS
SADLER
Creating Smiles That Are Out Of This World

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PATIENT INFORMATION

Date_____

PLEASE TELL US ABOUT YOU

Name: _____
LAST FIRST MI

I prefer to be called:_____

☐ Male ☐ Female

Date of Birth: _____/_____/_____ Age: _____

Home Address: _____

_____
CITY STATE ZIP

Home #: (_____) _____

E-mail Address: _____

SS #: _____

Employer: _____

Occupation: _____

No. years with present employer: _____

Work #: (_____)_____

Cell #: _____

YOUR GENERAL DENTIST

Name: _____ Last visit: _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE? _____

_____

Other referrals: _____

Other family members seen by us: _____

SPOUSE

Name: _____

Employer: _____

Occupation: _____ # Years: _____

Work #: (_____)_____

SS #: _____

RESPONSIBLE PARTY AND INSURANCE INFORMATION

Name: _____ SS #: _____

Address: _____ ☐ OWN ☐ RENT
STREET CITY STATE ZIP

How long at this address: _____ Home #: (_____) _____ Work #: (_____) _____

Previous address (if less than 3 yrs.): _____
STREET CITY STATE ZIP

Employer: _____ Occupation: _____ No. Years Employed: _____

PRIMARY ORTHODONTIC INSURANCE

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Name: _____

Insurance Address: _____

_____
CITY STATE ZIP

Insurance Phone #: (_____) _____

Group # (plan or policy #): _____

Insured's Name: _____

Relationship to patient: _____

Insured's Birthday: _____

Insured's Employer: _____

SECONDARY ORTHODONTIC INSURANCE

Orthodontic Coverage? ☐ Yes ☐ No _____

Insurance Name: _____

Insurance Address: _____

_____
CITY STATE ZIP

Insurance Phone #: (_____) _____

Group # (plan or policy #): _____

Insured's Name: _____

Relationship to patient: _____

Insured's Birthday: _____

Insured's Employer: _____

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Orthodontics Dedicated to Patient Satisfaction & High Ethical Standards

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Member American Association of Orthodontists

DENTAL HISTORY

WHAT ARE THE MAIN CONCERNS THAT YOU WOULD LIKE ORTHODONTICS TO ADDRESS?

_____

_____

_____

	YES	NO
Are you currently in pain?	☐	☐
Have you ever had a serious/difficult problem with any previous dental work?	☐	☐

Your current dental health is: _____

Do you like your smile?	☐	☐
Do your gums ever bleed?	☐	☐

How many times a week do you floss? _____

How many times a day do you brush? _____

Have you ever been evaluated by an orthodontist or had orthodontic treatment?	☐	☐
Have you ever had severe injuries to the face, mouth, teeth, or chin?	☐	☐
Have you ever been informed of any missing or extra permanent teeth?	☐	☐
Have you ever had any pain or tenderness in your jaw joint (TMJ or TMD)?	☐	☐

MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

PHYSICIAN'S NAME: _____

Phone #: (_____) _____ Last Visit _____

In the event of an emergency, is there someone who lives near you that we should contact? ☐ Yes ☐ No

Name: _____ Relationship: _____

Work #: (_____) _____ Home #: (_____) _____

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 taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

	YES	NO
Rheumatic Fever	☐	☐
Heart Murmur	☐	☐
Heart Problems	☐	☐
Diabetes	☐	☐
Bone Disorders	☐	☐
Blood Disorders	☐	☐
Cancer	☐	☐
Tuberculosis	☐	☐

	YES	NO
Ulcers	☐	☐
Fainting/Dizzy Spells	☐	☐
Hepatitis	☐	☐
HIV/AIDS	☐	☐
Mental Health Disorders	☐	☐
Herpes (any type)	☐	☐
Endocrine Disorders	☐	☐
Nervous Disorders	☐	☐

	YES	NO
Convulsions/Epilepsy	☐	☐
Handicaps/Disabilities	☐	☐
Allergies to latex/plastic	☐	☐
Hearing Disorders	☐	☐
Sinus Trouble	☐	☐
Asthma	☐	☐
Any Operations	☐	☐

☐ Hospital ☐ In-patient

Please discuss any medical problems that you have had: _____

_____

_____

I understand that the information I have given above is correct to the best of my knowledge, that where appropriate credit bureau reports will be obtained, and that it will be held in strict confidence. It is my responsibility to inform Dr. Sadler of any changes in my medical and dental status. I hereby authorize release of information for any proposed treatment to my/our insurance company and for insurance payment of said treatment to be paid directly to Sadler Orthodontics. I further authorize release of orthodontic records to other healthcare providers involved in my dental/orthodontic care and the use of these records by Dr. Sadler for teaching purpose and or scientific publication. In addition, I acknowledge that I have received a notice of privacy practices from Sadler Orthodontics.

_____ _____

Signature of Patient Date Signature of Insured Date

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