



Charles A. Sadler, Jr., D.D.S., M.S.D.

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 #: (_____) _____

Cell Service Provider: _____

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 #: (_____) _____

Cell #: (_____) _____

SS #: _____

RESPONSIBLE PARTY AND INSURANCE INFORMATION

Name: _____ SS #: _____

Address: _____ STREET CITY STATE ZIP OWN RENT

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: _____

Orthodontics Dedicated to Patient Satisfaction & High Ethical Standards

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DENTAL HISTORY

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

| | YES | NO |
|---|--------------------------|--------------------------|
| Are you currently in pain? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a serious/difficult problem with any previous dental work? | <input type="checkbox"/> | <input type="checkbox"/> |
| Your current dental health is: _____ | | |
| Do you like your smile? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do your gums ever bleed? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had severe injuries to the face, mouth, teeth, or chin? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been informed of any missing or extra permanent teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had any pain or tenderness in your jaw joint (TMJ or TMD)? | <input type="checkbox"/> | <input type="checkbox"/> |

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 | | YES | NO | | YES | NO |
|-----------------------|--------------------------|--------------------------|-------------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|
| Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers | <input type="checkbox"/> | <input type="checkbox"/> | Convulsions/Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | Fainting/Dizzy Spells | <input type="checkbox"/> | <input type="checkbox"/> | Handicaps/Disabilities | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Problems | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | Allergies to latex/plastic | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS | <input type="checkbox"/> | <input type="checkbox"/> | Hearing Disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| Bone Disorders | <input type="checkbox"/> | <input type="checkbox"/> | Mental Health Disorders | <input type="checkbox"/> | <input type="checkbox"/> | Sinus Trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood Disorders | <input type="checkbox"/> | <input type="checkbox"/> | Herpes (any type) | <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Endocrine Disorders | <input type="checkbox"/> | <input type="checkbox"/> | Any Operations | <input type="checkbox"/> | <input type="checkbox"/> |
| Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | Nervous Disorders | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Hospital <input type="checkbox"/> 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