Welcome to our office.

Erickson - Aamodt Orthodontics

Patient I.D. _____

So that we might become better acquainted, please complete both sides of this form.

Date: _____

ADULT PATIENT INFORMATION

Patient's Name: _____ Prefer to be called: _____ Sex: _____
LAST FIRST MIDDLE INITIAL

Address: _____ City: _____ Zip: _____

Home Phone: _____ Birthdate: _____ SS# _____

Patient's Dentist: _____ Referred by: _____

Do you know a patient currently in our practice? ☐ Yes ☐ No If yes, whom? _____

Who noticed orthodontic problem? ☐ Patient ☐ Dentist ☐ Other: _____

Describe the orthodontic problem in your own words: _____

What concerns you most about the thought of orthodontic treatment?

☐ appearance in applicances ☐ cost ☐ length of time ☐ discomfort ☐ results ☐ other: _____

Occupation: _____

Employer: _____ Address: _____ Wk Phone: _____

FAMILY AND ACCOUNT INFORMATION **Status:** (circle) **M S Wid Sep Div**

Spouse's Name: _____ Employer: _____ Wk Phone: _____

Person responsible for account: _____

If other than self or spouse:

Name: _____ Occupation: _____ SS#: _____

Address: _____ City: _____ Phone: _____

Name of Relative in Area: _____ Phone: _____

Names and ages of children: _____

INSURANCE INFORMATION

A dental insurance policy is a contract between the insured and the insurance company. Our professional services are rendered and charged directly to the patient's account and **the patient or person responsible for the account is responsible for payment of all fees incurred**.

Do you have orthodontic insurance coverage? ☐ No ☐ Yes — If yes, please fill in insurance information.

Name of Insured (Employee) _____ SS# _____ Date of Birth _____

Name of Insurance Company _____ Group # _____

Insurance Co. Mailing Address _____ Ins. Co. Phone _____

IF DUAL COVERAGE:

Name of Insured (Employee) _____ SS# _____ Date of Birth _____

Name of Insurance Company _____ Group # _____

Insurance Co. Mailing Address _____ Ins. Co. Phone _____

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your dental care. All information will be kept completely confidential.

MEDICAL HISTORY

Physician's Name: _____ Address: _____ Phone: _____

Have you experienced any health problems? ☐ No ☐ Yes Explain: _____
Any major change in your health recently? ☐ No ☐ Yes Explain: _____
Are you currently under physician's care? ☐ No ☐ Yes Explain: _____
Are you currently taking medications? ☐ No ☐ Yes List: _____
Are you allergic to any medications? ☐ No ☐ Yes List: _____
Have you received a blood transfusion? ☐ No ☐ Yes Reason: _____
Have your tonsils or adenoids been removed? ☐ No ☐ Yes When: _____
Have you been in a risk group for AIDS? ☐ No ☐ Yes Explain: _____

Please check if you have had any of the following conditions:

Heart Murmur	☐ No ☐ Yes	Hepatitis	☐ No ☐ Yes	Emotional Problems	☐ No ☐ Yes
Heart Surgery	☐ No ☐ Yes	Diabetes	☐ No ☐ Yes	Frequent Headaches	☐ No ☐ Yes
Rheumatic Fever	☐ No ☐ Yes	Kidney Disease	☐ No ☐ Yes	Nervous/Anxious	☐ No ☐ Yes
Endocrine Disorders	☐ No ☐ Yes	Liver Disease	☐ No ☐ Yes	Cancer	☐ No ☐ Yes
Prolonged Bleeding	☐ No ☐ Yes	Tuberculosis	☐ No ☐ Yes	Bone Disorders	☐ No ☐ Yes
Anemia	☐ No ☐ Yes	Bronchitis	☐ No ☐ Yes	Growth Disorders	☐ No ☐ Yes
Blood Disease	☐ No ☐ Yes	Asthma	☐ No ☐ Yes	Mouth Breather	☐ No ☐ Yes
Developmental Disorder	☐ No ☐ Yes	Epilepsy	☐ No ☐ Yes	Herpes (Fever Blisters)	☐ No ☐ Yes
Hives/Rash	☐ No ☐ Yes	Fainting	☐ No ☐ Yes	Tonsillitis	☐ No ☐ Yes

Is there any other condition or problem that you think we should know about? _____

Comments: _____

DENTAL HISTORY

Dentist's Name: _____ Address: _____ Phone: _____
Dental Specialist Name: _____ Address: _____ Phone: _____

Frequency of dental checkups: ☐ Twice a year ☐ Once a year ☐ Only if a problem exists ☐ Never Date of last visit: _____
Is there any unfinished care to be completed with your dentist? ☐ No ☐ Yes Explain: _____
Are you frightened about dental treatment? ☐ No ☐ Yes Explain: _____
Have you had an unpleasant experience in a dental office? ☐ No ☐ Yes Explain: _____
Have you had any face or dental injuries? ☐ No ☐ Yes Explain: _____
Do you play any musical instrument? ☐ No ☐ Yes What instrument? _____
Have you consulted an orthodontist previously? ☐ No ☐ Yes With whom? _____
Have teeth (either primary or permanent) been removed? ☐ No ☐ Yes
Have you had any previous orthodontic **treatment**? ☐ No ☐ Yes With whom? _____
Are you satisfied with prior treatment? ☐ No ☐ Yes Explain: _____
Have you noticed any changes in your bite or dental alignment recently? ☐ No ☐ Yes Explain: _____

What are the chief concerns you have related to the position of your teeth or bite:

☐ Aesthetic ☐ Cleaning ☐ Comfort ☐ Ability to chew ☐ Stability

Please elaborate: _____

What concerns has your dentist(s) expressed concerning your bite or dental alignment:

☐ Wear or fractures of teeth ☐ Difficulty with cleaning related to alignment of teeth
☐ Bone or gum tissue loss ☐ Jaw joint or muscle tightness or discomfort
☐ Alignment of teeth prior to restorative dental work (crowns, bridges, etc.)
☐ Other _____

Please check if there is a history of:

☐ Clenching teeth ☐ Muscular soreness around head & neck ☐ Jaw joint soreness ☐ Jaw joint popping
☐ Grinding teeth ☐ Headaches (more than normal) ☐ Jaw joint clicking ☐ Ringing in the ears
☐ Speech problems (if so, which sounds _____) ☐ Mouthbreathing while: ☐ Awake ☐ Asleep

Is there any other information that may be helpful? _____

_____ _____ Reviewed by: _____
Patient's Signature Date