



WELCOME, were glad you're here!

Today's Date: _____

Name: (LAST, FIRST, MI) _____ I prefer to be called: _____
Birthdate: ____/____/____ **Age:** _____ **Marital Status:** Single Married Divorced Widowed Separated
Home Address: _____
STREET APT/CONDO # CITY STATE ZIP
E-Mail Address: _____ **SS #:** _____
Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____ **Ext:** _____
Employer: _____ **Employer's Address:** _____
Occupation: _____ **How long there?** _____
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:** _____

Spouse Information

His/Her Name: _____ **Employer:** _____
Work Phone: _____ **Ext:** _____ **SS #:** _____ **Birthdate:** ____/____/____
Person Responsible for Account:
Work Phone: _____ **Ext:** _____ **Home Phone:** _____ **Cell Phone:** _____
Billing Address: _____ **Relation:** _____
SS #: _____ **Employer:** _____

Orthodontic Insurance

Primary

Orthodontic Coverage: Yes No **Dental Coverage:** Yes No
Insurance Co. Name: _____ **Ins. Co. Phone:** _____
Insurance Co. Address: _____
Group # (Plan, Local or Policy #): _____
Insured's Name: _____ **Relation:** _____
Insured's Birthdate: ____/____/____ **Insured's ID #:** _____ **Insured's Employer:** _____

Secondary

Orthodontic Coverage: Yes No **Dental Coverage:** Yes No
Insurance Co. Name: _____ **Ins. Co. Phone:** _____
Insurance Co. Address: _____
Group # (Plan, Local or Policy #): _____
Insured's Name: _____ **Relation:** _____
Insured's Birthdate: ____/____/____ **Insured's ID #:** _____ **Insured's Employer:** _____

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

His/Her Name: _____ **Relation:** _____
Work Phone: _____ **Home Phone:** _____

Medical History

Do you have a personal physician? Yes No **Physician's Name:** _____
Phone: _____ **Date of Last Visit:** _____

ORTHO ADULT

CONTINUED ON BACK

6801 South Minnesota Avenue, Sioux Falls, SD 57108

Phone: 605-274-0555



7109 West 26th Street, Sioux Falls, SD 57106

www.WermersonOrthodontics.com

Medical History *continued*

Your current 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 using a prescribed method of birth control? Yes No

Are you pregnant? Yes No Week #: _____ Are you nursing? Yes No

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

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

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

Are you allergic to any of the following?

| | | |
|---------------------------|------------------------|------------------|
| Y N Aspirin | Y N Dental Anesthetics | Y N Penicillin |
| Y N Any Metals / Plastics | Y N Erythromycin | Y N Tetracycline |
| Y N Codeine | Y N Latex | Y N Other |

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

Dental History

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

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

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

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

Your current dental health is: Good Fair Poor

Do you like your smile? Yes No

Have you ever had an injury to your (please circle): Mouth Teeth Chin

Do you have speech problems? Yes No

Do you generally breathe through your mouth? Yes No If yes, please circle: While Awake? While Asleep?

Do you have any dental implants? Yes No

Have you ever taken Fosamax, or any other biphosphonate? Yes No

Do you smoke or use tobacco in any form? Yes No

Do you require antibiotics before dental care? Yes No

Our office is HIPAA 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 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 that I may need during diagnosis and treatment with my informed consent.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office.

Signature _____

Date _____

Signature _____

Date _____

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY
I verbally reviewed the medical / dental information above with the patient named herein.

Initials: _____ Date: _____ Doctor's Comments: _____



Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I, _____ have received a copy of Wermerson Orthodontics
(Parent/Guardian print name) Notice of Privacy Practices.

(Please print Patient Name)

(Patient/Parent/Guardian signature)

(Date)

For Wermerson Orthodontics office use, in the event the Notice of Privacy Practices isn't signed. We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

- Individual refused to sign
 - Communications barriers prohibited obtaining the acknowledgement
 - An emergency situation prevented us from obtaining the acknowledgement
 - Other (Please specify)
- _____

