

Welcome to



Hudson & Axelrod
ORTHODONTICS

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

Please fill out this form completely. The better we communicate, the better we can care for you.

1 About You

Today's Date: _____

Name: _____

I prefer to be called: _____

Birthdate: ___/___/___ Age: _____ Male Female

Home Address: _____
APT/CONDO # _____

CITY STATE ZIP

Single Married Divorced Widowed Separated

Hm #: (____) _____ Pager/other #: _____

Wk #: (____) _____ Ext: _____

Employer: _____

Employer's Address: _____

How long there?: _____ Occupation: _____

Where and when are best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

General dentist: _____

2 Spouse Information

His/Her Name: _____

Employer: _____

Wk #: (____) _____ Ext: _____

Birthdate: ___/___/___ SS #: _____

3 Person Responsible for Account

_____ Hm #: (____) _____

Billing Address: _____ Wk #: (____) _____

Relation: _____ SS #: _____ Employer: _____

4 Orthodontic Insurance

PRIMARY

Orthodontic Coverage? Yes No Dental Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

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

Insured's Name: _____

Relation: _____

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

Insured's Employer: _____

SECONDARY

Orthodontic Coverage? Yes No Dental Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

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

Insured's Name: _____

Relation: _____

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

Insured's Employer: _____

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

His/Her Name _____ Relation: _____

Wk #: (____) _____ Hm #: (____) _____

6 Medical History

Do you have a personal physician? Yes No

Physician's Name: _____

Phone #: _____ Date of Last Visit: _____

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

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 that you are allergic to: _____

7 Dental History

What are the main concerns that 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 Gums ever bleed? Yes No

Have you ever had an injury to your: Mouth Teeth Chin

Do you have any speech problems? _____

Do you generally breathe through your mouth? Yes No

If yes, please check box: While awake? While asleep?

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

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

I hereby authorize payment to my attending Orthodontist. I understand that I am financially responsible for any charges not covered by this authorization. I also authorize release of any information relating to claims. I understand that, where appropriate, credit bureau reports may be obtained.

SIGNATURE

DATE

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

OFFICE USE ONLY

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

Doctors Comments:

Initials: _____ Date: _____

Initials: _____ Date: _____
