

MINOR PATIENT INFORMATION

Primary Phone _____

Referred By _____

NP Exam Date_____Time____Location_____

		Midd!-									
PATIENT: First		Middle		Last		SEX:	M □F	GENDER: □ M	UE U		
NICKNAME:				S WE'VE TREATED:			F BIRTH:				
NICKNAME.				S WE VE INLATED.		DATEO	/ /		AGE.		
HOBBIES:				GRADE / SCHOOL:		PATIEN	IT LIVES WIT	Ή:	<u> </u>		
							Both	Mothe	er 🗌 Fa	ather	Other
Fehrman Orthodontics following information ir not be disclosed for an	n its entirety. Your	Social Se	ecurity N	Number may be nee	eded to obtain credit	history,	or for filing	a claim wi			
MOTHER:	MAF	RITAL ST	ATUS:		FATHER:			MARITAL	STATUS:		
SOCIAL SECURITY #:		DATE OF	BIRTH:	/ /	SOCIAL SECURITY #	#:		DATE	OF BIRTH:	/	/
ADDRESS:	ľ				ADDRESS:			I			
CITY		S	STATE:	ZIP:	CITY				STATE:	ZIP:	
PRIMARY PHONE:		[□ Home	e 🗆 Cell 🗌 Work							
ALT. PHONE:		[🗌 Home	e 🗆 Cell 🗌 Work	ALT. PHONE:						
PROFESSION:	EMAIL ADDRESS:				PROFESSION:	1	EMAIL ADDR	RESS:			
SPOUSE (IF APPLICABLE):	•				SPOUSE (IF APPLIC)	ABLE):					
SOCIAL SECURITY #:		DATE OF	BIRTH:	/ /	SOCIAL SECURITY #	YITY #: D		DATE	ATE OF BIRTH: / /		/
Fehrman Orthodontics wi information in its entirety.									kam and fill	out the fo	ollowing
P	RIMARY DENTAL IN	ISURANC	E		SECONDARY DENTAL INSURANCE						
DENTAL CARRIER:					DENTAL CARRIER:						
POLICY HOLDER:	DOB:			REL TO PT:	POLICY HOLDER:		D	OB:		REL TO I	PT:
MEMBER #:	GROU	P #:			MEMBER #:		G	ROUP #:			
EMPLOYER:					EMPLOYER:						
INSURANCE CO. ADDRESS:					INSURANCE CO. ADDRESS:						
CITY:		S	STATE:	ZIP:	CITY:				STATE:	ZIP:	
INSURANCE CO. PHONE:					INSURANCE CO. PH	IONE:					
I hereby author	ize payment directly t	to Fehrma	n Orthod	ontics.	l hereby	authorize	e payment dir	ectly to Feh	rman Orthoo	lontics.	
Signature of Insured Person			Date	Signature of Insured Person					Da	ite	

ONE STATEMENT IS SENT. Please send to: Parents Father Mother Other

(Check at least one): HOW DO YOU PREFER TO BE REMINDED OF APPOINTMENTS: UM UTEXT EMAIL

I certify the information on this form is true to the best of my knowledge. I accept responsibility for the dental charges incurred. I understand my dental insurance provider may pay less than the actual bill for services and I am ultimately responsible for any balances due. I understand that I am responsible for any late fees, missed appointments and/or collection fees incurred. I acknowledge that Fehrman Orthodontics will provide me with a copy of their Privacy Practices upon request.

Patient Name:

Please use the space after the questions for additional explanations. Yes No Food getting stuck between teeth Has patient had a previous orthodontic exam Food getting stuck between teeth Has patient had a previous orthodontic reatment Does the patient fight where teeth Has patient had any or othodontic reatment Does the patient previous and teeth Has patient had any orthodontic reatment Does the patient previous and teeth Has patient had a previous orthodontic reatment Does the patient previous correct and the patient spin were tocked Does the patient bush daily Does the patient have patient have patient have patient his/her jaw joint Does the patient thoush daily Does the patient thoush daily Does the patient thoush daily Does the patient of the clicking or popping in his/her jaw Physician: Date of Last Visit Yes No Are you taking any medication? Yes No Have you had any operations? Yes No Have you had any opera		DENTAL HISTORY					
*** Please check Yes or No for the following questions, whichever applies. Your answers are for our records only and will be considered confidential. Please use the space after the questions for additional explanations. Yes No Yes No Has patient had a previous orthodontic exam Food getting stuck between teeth History of missing or extra teeth Does the patient cleanch his/her teeth Dest the patient cleanch his/her teeth Does the patient cleanch his/her teeth Dest the patient cleanch his/her teeth Does the patient cleanch his/her teeth Dest the patient have any permanent teeth been removed Does the patient cleanch his/her teeth Dest the patient toush daily Does the patient have any perparations. Dest the patient toush daily Does the patient notice cleang or popping in his/her jaw Dest the patient toush daily Does the patient notice cleang or popping in his/her jaw Physician:	ne of patient's dentist:	Date of last dental exam:					
*** Please check Yes or No for the following questions, whichever applies. Your answers are for our records only and will be considered confidential. Please use the space after the questions for additional explanations. Yes No Yes No Has patient had a previous orthodontic exam Food getting stuck between teeth Ibs apatient had any orthodontic treatment Ibs water fluoridated Ibs apatient had any orthodontic reatment Does the patient cleanch his/her teeth Ibs apatient had any orthodontic netword Does the patient cleanch his/her teeth Ibs apatient had apoint habit Does the patient have pain in his/her jaw joint Ibs apatient had apoint habit Does the patient have pain in his/her jaw joint Ibs apatient have patient floss daily Does the patient have pain or his/her teeth Ibs apatient have patient floss daily Does the patient have patient patient is patient appendix or matching apatient patient have patient floss daily Explain any condition(s) above:	at is your chief concern for us at this visit?						
Has patient had a previous orthodontic reatment Is water fluctuated any orthodontic treatment Is water fluctuated any orthodontic treatment Is water fluctuated any orthodontic treatment Does the patient clench his/her teeth Does the patient clench his/her teeth Does the patient dien bush or teeth Does the patient dien bush or teeth Does the patient dien bush dialy Does the patient dien dialy Please circle Yes or No (If Yes, please fill in details) Yes No Are you taking any medication? Yes No Have you ever been involved in a serious accident? Yes No Have you ever been involved in a serious accident? Yes No Require premedication prior to dental visits? For what condition? Yes No Require premedication prior to dental visits? For what condition? Yes No Raye you had any operations? Yes No Raye goend dien yo for dien alibitotics Circle any of the medical conditions below that you have had or currently have: Allergies or drug reactions to: Latex Di		our answers are for our records only and will b	be considered confidential.				
Physician:	 Has patient had a previous orthodontic exam Has patient had any orthodontic treatment Injury to the mouth or teeth History of missing or extra teeth Have any permanent teeth been removed Have tonsils or adenoids been removed Mouth breathing habit Chronic snoring Thumb or finger habit Does the patient brush daily Does the patient floss daily 	 Food getting stuck betwee Is water fluoridated Does the patient grind his Does the patient clench h Has the patient's jaw eve Does the patient have pa Does the patient experier of his/her face or aroun Does the patient notice c Frequent headaches / ne Does patient take fluoride 	s/her teeth his/her teeth r locked in in his/her jaw joint nce soreness in the muscles d the ears licking or popping in his/her jaw joint ckaches e supplements				
Please circle Yes or No (If Yes, please fill in details) Yes No Are you taking any medication?		MEDICAL HISTORY	[] Pregnant Due:				
Yes No Are you taking any medication?	rsician:	Date of Last Visit	[] Nursing				
Yes No Do you have a history of a major illness?	ase circle Yes or No (If Yes, please fill in details)						
Yes No Have you had any operations?	No Are you taking any medication?						
Yes No Have you ever been involved in a serious accident? Yes No Have seen a physician in the last 12 months? Why? Yes No Require premedication prior to dental visits? For what condition? Yes No Require premedication prior to dental visits? For what condition? Yes No Taking / have taken bisphosphonates (Fosamax, Actonel, Boniva, Zometa, Aredia, Skelid, Didronel) and medical reason for treat (severe bone disorders, cancers or osteoporosis/osteopenia) in past 5 years Allergies or drug reactions to: Latex Beneicillin or other antibiotics Sulfa drugs Penicillin or other antibiotics Codiene or other narcotics Circle any of the medical conditions below that you have had or currently have: Abnormal bleeding / Hemophilia Bone Disorders Allergies Hepatitis / Liver Problems Anemia Dizziness ADD Diabetes Anemia Dizziness Arthritis Epilepsy / Fainting Spells Asthma or Hayfever Gastrointestinal Disorders Asthma or Hayfever Heart Murmur Autism Heart Problems	No Do you have a history of a major illness?						
Yes No Have seen a physician in the last 12 months? Why? Yes No Require premedication prior to dental visits? For what condition? Yes No Taking / have taken bisphosphonates (Fosamax, Actonel, Boniva, Zometa, Aredia, Skelid, Didronel) and medical reason for treat (severe bone disorders, cancers or osteoporosis/osteopenia) in past 5 years Allergies or drug reactions to: Latex Sulfa drugs Food allergies: Allergies or drug reactions to: Latex Sulfa drugs Food allergies: Noickel / Metal Aspirin, Ibuprofen or Tylenol Food allergies: Penicillin or other antibiotics Codiene or other narcotics Rheumatic Fever Sleep Apnea Sleep Apnea Sleep Apnea ADHD Dizziness HIV / Aids Tuberculosis Arthritis Epilepsy / Fainting Spells Kidney Problems Tumor or Cancer Asthma or Hayfever Gastrointestinal Disorders Nervous Disorders Vision / Hearing Imp Autism Heart Murmur Pneumonia Sleep Apnea Blood Disorder Heart Problems Radiation / Chemotherapy Vision / Hearing Imp	No Have you had any operations?						
Yes No Require premedication prior to dental visits? For what condition? Yes No Taking / have taken bisphosphonates (Fosamax, Actonel, Boniva, Zometa, Aredia, Skelid, Didronel) and medical reason for treat (severe bone disorders, cancers or osteoporosis/osteopenia) in past 5 years Allergies or drug reactions to: Latex Sulfa drugs Food allergies: Image: No index of the medical conditions below that you have had or currently have: Nickel / Metal Aspirin, Ibuprofen or Tylenol Food allergies: Abnormal bleeding / Hemophilia Bone Disorders Hepatitis / Liver Problems Rheumatic Fever Acid Reflux Congenital Heart Defect Herpes Sleep Apnea ADHD Diabetes High Blood Pressure Speech Difficulty Arthritis Epilepsy / Fainting Spells Kidney Problems Tuberculosis Asthma or Hayfever Gastrointestinal Disorders Nervous Disorders Vision / Hearing Imp Autism Heart Murmur Pneumonia Badiation / Chemotherapy Vision / Hearing Imp	No Have you ever been involved in a serious accident?						
Allergies or drug reactions to: Latex Sulfa drugs Food allergies: Food allergies: Nickel / Metal Aspirin, Ibuprofen or Tylenol Codiene or other narcotics Food allergies: Food allergies: Circle any of the medical conditions below that you have had or currently have: Congenital Heart Defect Hepatitis / Liver Problems Rheumatic Fever Abnormal bleeding / Hemophilia Bone Disorders Heppes Sleep Apnea ADHD Diabetes High Blood Pressure Speech Difficulty Anemia Dizziness HIV / Aids Speech Difficulty Asthma or Hayfever Gastrointestinal Disorders Nervous Disorders Vision / Hearing Imp Autism Heart Murmur Pneumonia Pneumonia Vision / Hearing Imp Bood Disorder Heart Problems Radiation / Chemotherapy Vision / Hearing Imp	No Have seen a physician in the last 12 months? Why?						
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Nickel / Metal Aspirin, Ibuprofen or Tylenol Penicillin or other antibiotics Codiene or other narcotics Circle any of the medical conditions below that you have had or currently have: Abnormal bleeding / Hemophilia Abnormal bleeding / Hemophilia Bone Disorders Hepatitis / Liver Problems Acid Reflux Congenital Heart Defect Herpes ADHD Diabetes High Blood Pressure Anemia Dizziness HIV / Aids Arthritis Epilepsy / Fainting Spells Kidney Problems Asthma or Hayfever Gastrointestinal Disorders Nervous Disorders Autism Heart Murmur Pneumonia Blood Disorder Heart Problems Radiation / Chemotherapy	(severe bone disorders, cancers or osteoporosis/osteop	enia) in past 5 years					
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Are there any medical conditions we have not discussed that you feel we should be aware of?	id Reflux Congenital Heart Defect HD Diabetes emia Dizziness hritis Epilepsy / Fainting Spells thma or Hayfever Gastrointestinal Disorders tism Heart Murmur	Herpes High Blood Pressure HIV / Aids Kidney Problems Nervous Disorders Pneumonia	Sleep Apnea Speech Difficulty Tuberculosis				
	there any medical conditions we have not discussed that you	feel we should be aware of?					
If so, please explain:	,						

BENEFITS

Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment without adequate retention. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Fehrman Orthodontics to perform a complete orthodontic evaluation.