Fehrman Orthodontics

MINOR PATIENT INFORMATION

Primary Phone _____

Referred By _____

NP Exam Date _____ Time _____ Location _____

PATIENT: First Middle Last		SEX: ☐M ☐F	GENDER: ☐M ☐F ☐_____
NICKNAME:	FAMILY MEMBERS WE'VE TREATED:	DATE OF BIRTH: / /	AGE:
HOBBIES:	GRADE / SCHOOL:	PATIENT LIVES WITH: ☐ Both ☐ Mother ☐ Father ☐ Other	

Fehrman Orthodontics offers interest-free payment options based on credit worthiness. In order to set up your account at our office, please fill out the following information in its entirety. Your Social Security Number may be needed to obtain credit history, or for filing a claim with your insurance, and will not be disclosed for any other purpose. Please initial that you have read and understand this information. INITIAL: _____

MOTHER: MARITAL STATUS:			**FATHER:** MARITAL STATUS:		
SOCIAL SECURITY #:	DATE OF BIRTH: / /		SOCIAL SECURITY #:	DATE OF BIRTH: / /	
ADDRESS:			ADDRESS:		
CITY	STATE:	ZIP:	CITY	STATE:	ZIP:
PRIMARY PHONE: ☐Home ☐Cell ☐Work			PRIMARY PHONE: ☐Home ☐Cell ☐Work		
ALT. PHONE: ☐Home ☐Cell ☐Work			ALT. PHONE: ☐Home ☐Cell ☐Work		
PROFESSION:	EMAIL ADDRESS:		PROFESSION:	EMAIL ADDRESS:	
SPOUSE (IF APPLICABLE):			*SPOUSE (IF APPLICABLE):*		
SOCIAL SECURITY #:	*DATE OF BIRTH:* / /		*SOCIAL SECURITY #:*	*DATE OF BIRTH:* / /	

Fehrman Orthodontics will submit insurance claims on your behalf. Please bring your current dental insurance card(s) with you to your exam and fill out the following information in its entirety. We will verify your orthodontic coverage and provide you with an estimate for treatment based on this information.

PRIMARY DENTAL INSURANCE			**SECONDARY DENTAL INSURANCE**		
DENTAL CARRIER:			DENTAL CARRIER:		
POLICY HOLDER:	DOB:	REL TO PT:	POLICY HOLDER:	DOB:	REL TO PT:
MEMBER #:	GROUP #:		MEMBER #:	GROUP #:	
EMPLOYER:			EMPLOYER:		
INSURANCE CO. ADDRESS:			INSURANCE CO. ADDRESS:		
CITY:	STATE:	ZIP:	CITY:	STATE:	ZIP:
INSURANCE CO. PHONE:			INSURANCE CO. PHONE:		
I hereby authorize payment directly to Fehrman Orthodontics.			I hereby authorize payment directly to Fehrman Orthodontics.		
_____ *Signature of Insured Person*	_____ *Date*		_____ *Signature of Insured Person*	_____ *Date*	

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

(Check at least one): HOW DO YOU PREFER TO BE REMINDED OF APPOINTMENTS: ☐VM ☐TEXT ☐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.

Signature of Parent / Guardian: _____ Date: / /

Patient Name: _____

DENTAL HISTORY

Name of patient's dentist: _____ Date of last dental exam: _____

What is your chief concern for us at this visit? _____

** 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
☐	☐	Has patient had any orthodontic treatment	☐	☐	Is water fluoridated
☐	☐	Injury to the mouth or teeth	☐	☐	Does the patient grind his/her teeth
☐	☐	History of missing or extra teeth	☐	☐	Does the patient clench his/her teeth
☐	☐	Have any permanent teeth been removed	☐	☐	Has the patient's jaw ever locked
☐	☐	Have tonsils or adenoids been removed	☐	☐	Does the patient have pain in his/her jaw joint
☐	☐	Mouth breathing habit	☐	☐	Does the patient experience soreness in the muscles of his/her face or around the ears
☐	☐	Chronic snoring			
☐	☐	Thumb or finger habit	☐	☐	Does the patient notice clicking or popping in his/her jaw joint
☐	☐	Does the patient brush daily	☐	☐	Frequent headaches / neckaches
☐	☐	Does the patient floss daily	☐	☐	Does patient take fluoride supplements

Explain any condition(s) above: _____

_____

_____

MEDICAL HISTORY

☐ Pregnant Due: _____

Physician: _____ Date of Last Visit _____ ☐ Nursing

Please circle Yes or No (If Yes, please fill in details)

☐Yes ☐No Are you taking any medication? _____

☐Yes ☐No Do you have a history of a major illness? _____

☐Yes ☐No Have you had any operations? _____

☐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 Taking / have taken bisphosphonates (Fosamax, Actonel, Boniva, Zometa, Aredia, Skelid, Didronel) and medical reason for treatment (severe bone disorders, cancers or osteoporosis/osteopenia) in past 5 years _____

Allergies or drug reactions to:

☐ Latex
☐ Nickel / Metal
☐ Penicillin or other antibiotics
☐ Sulfa drugs
☐ Aspirin, Ibuprofen or Tylenol
☐ Codiene or other narcotics
☐ Food allergies: _____

Circle any of the medical conditions below that you have had or currently have:

☐Abnormal bleeding / Hemophilia
☐Acid Reflux
☐ADHD
☐Anemia
☐Arthritis
☐Asthma or Hayfever
☐Autism
☐Blood Disorder
☐Bone Disorders
☐Congenital Heart Defect
☐Diabetes
☐Dizziness
☐Epilepsy / Fainting Spells
☐Gastrointestinal Disorders
☐Heart Murmur
☐Heart Problems
☐Hepatitis / Liver Problems
☐Herpes
☐High Blood Pressure
☐HIV / Aids
☐Kidney Problems
☐Nervous Disorders
☐Pneumonia
☐Radiation / Chemotherapy
☐Rheumatic Fever
☐Sleep Apnea
☐Speech Difficulty
☐Tuberculosis
☐Tumor or Cancer
☐Vision / Hearing Impaired

Are 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.

Signature of Parent / Guardian: _____ Date: _____