VINCENT & BULLWINKEL

ORTHODONTICS

Today's Date: _____

Patient's Date of Birth: _____

Patient's Name: _____ Age: _____ Sex: M ☐ F ☐

Patient's Preferred Name: _____ Primary Phone Number: _____

Home Address: _____ Zip Code: _____

Marital Status: Married ☐ Divorced ☐ Separated ☐ Single ☐

Employer: _____ Business Phone: _____

Business Address: _____ Soc Sec No: _____

Name of spouse: _____ Occupation: _____

Employer: _____ Business Phone: _____

Business Address: _____ Soc Sec No: _____

Who will be responsible for the account? _____ Relation to Patient: _____

Date of Last Dental Visit: _____

Primary Dentist: _____ Primary Physician: _____

Whom may we thank for referring you? _____

Are you in good health? Yes ☐ No ☐ Any history of major illness? Yes ☐ No ☐

Are you presently under the care of a physician for a specific problem? Yes ☐ No ☐

If yes, please explain: _____

List any medications taken and why: _____

_____

List any drug sensitivities: _____

PLEASE CHECK THE FOLLOWING AS THEY APPLY

☐ Contact Lenses	☐ High Blood Pressure	☐ Allergies or Asthma	☐ Speech Problems
☐ Glaucoma	☐ Head or Facial Injury	☐ Rheumatic Fever	☐ Emotional Problems
☐ Heart Trouble	☐ Tonsillitis	☐ Diabetes	☐ Endocrine Problems
☐ Kidney Disease	☐ Hearing Disorder	☐ Bleeding Problems	☐ Nervous Disorders
☐Hepatitis/Liver Disease	☐ Chronic Ear Infections	☐ Epilepsy	☐ Adopted

Is there a history of serious illness, accident, or operation? Yes ☐ No ☐

Please List: _____

Have there been any injuries to the face/mouth/teeth? _____

Have you ever had gum disease? _____

Have you been informed of any missing or extra permanent teeth? _____

Has an orthodontist been consulted previously? _____

Have you had any previous orthodontic treatment? _____

Where? _____

Has anyone in your family had orthodontic treatment? _____

Do you have an unusual amount of stress in your life? _____

Reason for seeking orthodontic treatment: _____

_____

Please list additional information which you feel may be helpful: _____

_____

Do you have dental insurance that covers orthodontic treatment? Yes ☐ No ☐

If yes, please complete next page

DENTAL/ORTHODONTIC INSURANCE INFORMATION

To best assist your family in determining orthodontic benefits, the following information is necessary.

Name of Patient: _____ Date of Birth: _____

Name of Insured: _____ Date of Birth: _____

Relationship to patient: _____

Address: _____

Social Security #: _____ Telephone: _____

Employer: _____ Telephone: _____

Employer's Address: _____

Insurance Company: _____ Policy/Group #: _____

Address of Insurance Company: _____

Insurance Company Telephone: _____

IF THE PATIENT HAS ADDITIONAL COVERAGE, PLEASE PROVIDE THAT INFORMATION BELOW

Name of Insured: _____ Date of Birth: _____

Relationship to patient: _____

Address: _____

Social Security #: _____ Telephone: _____

Employer: _____ Telephone: _____

Employer's Address: _____

Insurance Company: _____ Policy/Group #: _____

Address of Insurance Company: _____

Insurance Company Telephone: _____

I hereby authorize the release of any information relating to this claim.

_____ _____

Signature Date

I hereby authorize the payment of insurance benefits directly to the named orthodontist.

_____ _____

Signature Date

TEMPOROMANDIBULAR JOINT EVALUATION

1. Please describe your current problem in your own words:_____

_____

_____

_____

2. Do you have any difficulty opening your mouth? Yes No
3. Do you hear any noises from the "jaw joint(s)"? Yes No
4. Does your jaw get "stuck," "locked," or "go out"? Yes No
5. Do you constantly grind your teeth at night? Yes No
6. Do you constantly clench your teeth together? Yes No
7. Do you have headaches? Yes No
8. Do you have neck pain? Yes No
9. Do you have ear aches? Yes No
10. Do you have muscle spasms in your cheek area? Yes No

If you answered yes to any of the above….

1. Is the pain constant? Yes No
2. Is the pain worse in the mornings? Yes No
3. Is the pain worse in the afternoon? Yes No

Please describe the type of pain in your own words: _____

_____

11. Do you have any pain when chewing, yawning, or opening wide? Yes No
12. Does your bite feel unusual or uncomfortable? Yes No
13. Have you ever had any injury to your jaw, head, or neck? Yes No

If yes, please explain: _____

_____

14. Do you have arthritis or any bone disorders? Yes No
15. Do you have an unusual amount of stress in your life? Yes No
16. Have you ever been treated for TMJ disorder? Yes No

If yes, please explain when, how, and by whom: _____

_____

_____

ACKNOLWEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

Patient's Name: _____

I, _____ have received a copy of this office's notice of privacy practices.

Name (Please print): _____

Signature: _____

Date: _____

Email Address: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign ☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other: _____

VINCENT & BULLWINKEL

ORTHODONTICS