RYAN ORTHODONTICS

*A Smile is for life*

## Patient Information

Date:_____

Name:_____
First MI Last

Birth Date:_____/_____/_____ Age:_____

Home Address: _____

_____
City State Zip

Home Phone#_____

Cell Phone#_____

Email:_____

Other family members treated in our office:

_____

Who may we THANK for referring you?

_____

## Responsible Party's Information

Name:_____

If other than patient, please complete below:

Relationship to patient: _____

Home/Billing Address: (if different)

_____

_____
City State Zip

Email: _____

Home phone # :_____

Cell # : _____

Occupation: _____

Employer: _____

Work phone #: _____

Years employed there: _____

## Dental Insurance

Policy Holder
Name:_____

Relationship to Patient:_____

Employer:_____

Birth Date:____/____/_____

SS#:_____

ID#:_____

Group#:_____

Insurance Company:_____

Phone#:_____

Address:_____

_____

Do you have secondary coverage? YES NO

If so please list:

_____

*Our office will assist in filling your insurance information if you can provide proper information. We will not accept responsibility for collecting from your insurance or for negotiating a settlement for disputed claims. Any parties noted on this form will be allowed access to your protected health information unless excluded by written request.*

## Emergency Contact

Name:_____

Relationship:_____

Phone#_____

## Dental History

What concerns you most about your teeth?

_____

Do you have any present dental problems? _____
Do you have any periodontal problems? _____
Have you ever had any pain or tenderness in the jaw joint? _____
Have you had previous orthodontic treatment? _____
Have you been under another dental specialist's care? _____
Have there been any injuries to face, mouth or teeth? _____
Do you have any previous or present tongue, thumb or finger habits?
_____

If you answered yes to any of the above, please explain:

_____

_____

Do the following apply to you?

| | | |
|---|---|---|
| Tooth Sensitivity | _____ Yes | _____ No |
| Pain or ringing in ears | _____ Yes | _____ No |
| Mouth breathing | _____ Yes | _____ No |
| Grinding or clenching | _____ Yes | _____ No |

## Dentist Information

Dentist Name:_____ Town:_____

Phone#: _____Date of last visit:_____

## Physician Information

Physician Name:_____

Phone#_____ Last visit:_____

Are you currently under the care of a physician? YES/NO
Explain:_____

## Allergies

Yes No Latex Yes No Nickel

Please list any other allergies: _____

_____

## Medical History

| | | | | | |
|---|---|---|---|---|---|
| Yes | No | AIDS/HIV+ | Yes | No | Hepatitis |
| Yes | No | Abnormal bleeding | Yes | No | Kidney problem |
| Yes | No | Asthma | Yes | No | Liver problem |
| Yes | No | Cancer | Yes | No | Sinus Trouble |
| Yes | No | Cardiac Problems | Yes | No | Thyroid problems |
| Yes | No | Diabetes | Yes | No | Epilepsy |
| Yes | No | Drug addiction | Yes | No | Venereal Disease |
| Yes | No | Eating disorder | Yes | No | Tuberculosis |
| Yes | No | Tonsil/Adenoid Condition | | | |
| Yes | No | Hearing Impairment | | | |
| Yes | No | Handicap/Disability | | | |
| Yes | No | Mental Health issues | | | |
| Yes | No | Surgical procedure | | | |

Please explain any serious medical problems you have had:

_____

_____

_____

Please list any medications you are currently taking and the correlating diagnosis:

_____

_____

**Women:**

Are you pregnant? _____

Due date: _____

## Premedication

Yes No Heart Murmur
Yes No History of Rheumatic Fever
Yes No Has been instructed to take any medication prior to dental treatment.

_____

_____

_____

**Our office has been committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.**

## Legal Statement

I understand the information that I have given is correct to the best of my knowledge and that it will be handled in accordance with the office privacy policy. If there are any changes during the duration of treatment, I will so inform this practice. I will not hold my orthodontist or any staff member responsible for any errors or omissions that I have made in the completion of this form.

**Signature:** _____ **Date:** _____

I authorize the orthodontic staff to perform any necessary dental services that I may need, with my informed consent. I understand that I am responsible for all costs of orthodontic treatment. I authorize release of any information needed to process insurance claims and hereby authorize payment of the orthodontic benefits otherwise payable to me directly to the provider.

**Signature:** _____ **Date:** _____