



FOR ADULTS: WELCOME TO OUR PRACTICE
Please Complete Thoroughly

ABOUT YOU

Today's Date: DOB: Age: M F
Name (Mr. Mrs. Ms): (last) (first) I prefer to be called:
SS#: Home Phone#: Cell#:
Home Address: City: Zip:
How long have you been at this address? Email:
Present Dentist: Date of last cleaning: Phone Number:
Your current dental health is: Good Fair Poor
Who may we thank for referring you?
Other family members seen by us:

ABOUT YOUR EMPLOYER

Name: How long have you worked there?
Address: City: Zip:
Occupation: Phone #: Ext:

SPOUSE INFORMATION

Name: SS#: DOB:
Cell #: Email Address:
Employer: Work #: Ext:
Occupation: How long have you worked there?

EMERGENCY CONTACT

Name: Relation:
Home #: Cell #: Work #:

PRIMARY ORTHODONTIC INSURANCE

Insurance Name: Phone #:
Insurance Company Address:
Insured's Name: Relationship to Patient:
Group #: ID/Policy #:

SECONDARY ORTHODONTIC INSURANCE

Insurance Name: Phone #:
Insurance Company Address:
Insured's Name: Relationship to Patient:
Group #: ID/Policy #:

**GENERAL INFORMATION**

Has the child ever had a serious/difficult problem associated with dental work? Yes \_\_\_ No \_\_\_  
Has the child ever had any pain or tenderness in the jaw joint (TMJ/TMD)? Yes \_\_\_ No \_\_\_  
Does the child brush teeth daily? Yes \_\_\_ No \_\_\_  
Does the child floss teeth daily? Yes \_\_\_ No \_\_\_  
Is the child currently under the care of a physician? Yes \_\_\_ No \_\_\_  
Child's Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_ Last Visit: \_\_\_\_\_  
Please describe the child's health: Good \_\_\_ Fair \_\_\_ Poor \_\_\_  
Please list all drugs the child is currently taking: \_\_\_\_\_

Please list all drugs the child is allergic to: \_\_\_\_\_  
Does your child have any latex allergies? Yes \_\_\_ No \_\_\_

**MEDICAL HISTORY**

Heart Murm	Yes ___ No ___	Congenital Heart Def	Yes ___ No ___
Cancer	Yes ___ No ___	Convulsions/Epilepsy	Yes ___ No ___
Diabetes	Yes ___ No ___	Abnormal Bleeding	Yes ___ No ___
Rheum Fev	Yes ___ No ___	Hearing Impairment	Yes ___ No ___
HIV+/AIDS	Yes ___ No ___	Any Operations	Yes ___ No ___
Hemophilia	Yes ___ No ___	Any stays in Hospital	Yes ___ No ___
Asthma	Yes ___ No ___	Kidney/Liver Problems	Yes ___ No ___
Hepatitis	Yes ___ No ___	Handicaps/Disabilities	Yes ___ No ___
Tuberculosis	Yes ___ No ___	Allergies to Any Drugs	Yes ___ No ___
Prosthesis	Yes ___ No ___	History of Scarlet Fever	Yes ___ No ___

Please discuss any serious medical problems that the child has had: \_\_\_\_\_

Does the child have any of the following habits:

Thumb sucking/Finger sucking	Yes ___ No ___
Lip sucking/biting	Yes ___ No ___
Nail Biting	Yes ___ No ___
Nursing Bottle Habits	Yes ___ No ___

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA. I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I hereby authorize Orthobanc, LLC, on behalf of Frigo Orthodontics to obtain a copy of my credit report form from a credit reporting agency for the purpose of considering payment options.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

The parent/guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved

**OFFICE USE ONLY**

I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein:

\_\_\_\_\_  
Initials

\_\_\_\_\_  
Date

\_\_\_\_\_  
Doctor's Comments