WELCOME TO JENKINS ORTHODONTICS

Thank you for choosing our office to address your orthodontic concerns. Please take a few minutes to fill out both pages of this form as completely as you can. If you have questions we will be glad to help you.

PATIENT INFORMATION

Patient's Name _____ Preferred Name _____

Male _____ Female _____ Date of Birth _____ Age _____

Address _____ City _____ State _____ Zip _____

Phone number _____ E-Mail address _____

Are you: Minor _____ Single _____ Married _____ Divorced _____ Separated _____ Widowed _____

If you are a student, name of school _____ Hobbies/Interest _____

Person to notify in case of emergency _____ Phone number _____

Whom may we thank for referring you to us? _____

RESPONSIBLE PARTY INFORMATION

Name _____ Relationship to patient _____

Address _____ City _____ State _____ Zip _____

Name of employer _____ Occupation _____

Best number to contact _____ Best time to contact _____

Is this number: Home ____ Work ____ Cell ____ E-mail Address _____

INSURANCE INFORMATION

Subscriber's Name _____ Relationship to patient _____

Birthdate _____ Social Security Number _____

Name of employer _____ Occupation _____

Business address _____ City _____ State _____ Zip _____

Insurance Company _____ Group or ID number _____

SECONDARY COVERAGE

Subscriber's Name _____ Relationship to patient _____

Birthdate _____ Social Security Number _____

Name of employer _____ Occupation _____

Business address _____ City _____ State _____ Zip _____

Insurance Company _____ Group or ID number _____

DENTAL HISTORY

What specifically brings you to our office? _____

How do you feel about the appearance and health of your teeth? _____

Name of your general dentist _____ Phone number _____

Date of last dental visit _____ Date of last x-rays _____

How often do you brush? _____ How often do you floss? _____

Indicate which of the following you have had or have at the present:

	Yes	No		Yes	No
Bleeding gums	☐	☐	Loose teeth	☐	☐
Clicking or popping jaw	☐	☐	Mouth breathing	☐	☐
Food collection between teeth	☐	☐	Periodontal treatment	☐	☐
Grinding or clenching teeth	☐	☐	Thumb / Finger habit	☐	☐
Injury to mouth or chin	☐	☐	Previous orthodontic treatment	☐	☐
			If yes, when _____		

MEDICAL HISTORY

Are you currently under physician care? Yes __No___ If yes, explain _____

Physician's Name _____ Phone Number _____

Indicate which of the following you have had or have at the present:

	Yes	No		Yes	No
Abnormal Bleeding	☐	☐	Hearing Impairment	☐	☐
Allergy to Latex	☐	☐	Heart Disease	☐	☐
Allergy to Metal	☐	☐	Heart Murmur	☐	☐
Anemia	☐	☐	Hepatitis	☐	☐
Asthma	☐	☐	HIV/AIDS	☐	☐
Blood Transfusion	☐	☐	High Blood Pressure	☐	☐
Cancer	☐	☐	Hospitalization	☐	☐
Cold Sores	☐	☐	Kidney/Liver Disease	☐	☐
Congenital Heart Defect	☐	☐	Mental Disorders	☐	☐
Convulsion / Epilepsy	☐	☐	Operations	☐	☐
Diabetes	☐	☐	Pregnancy	☐	☐
Drug Allergies	☐	☐	Rheumatic/Scarlet Fever	☐	☐
Food Allergies	☐	☐	Respiratory troubles	☐	☐
Fainting	☐	☐	Tuberculosis	☐	☐
Headaches	☐	☐	Other _____		

Do you have any health problems that need further clarification? Yes ___No____

If yes, please explain _____

List all medications you are currently taking _____

I, the undersigned, have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I authorize Jenkins Orthodontics to obtain eligibility information from my insurance company, if applicable.

Signature _____ Date _____