

WELCOME TO OUR OFFICE

DONNELLY ORTHODONTICS Inc.

Please fill out both pages of this form

Name _____ Male / Female

Address _____ City _____ State _____ Zip _____

Date of Birth ____ / ____ / ____ Phone _____

E-Mail Address _____

Emergency/ Alternate contact not living with you:

Name _____ Phone _____

Hobbies: _____

Dentist: _____

Who referred you to our office: _____

Siblings: Name _____ DOB _____ Name _____ DOB _____

Responsible Billing Information:

Name _____ Address _____

Home Phone _____ Work Phone _____

Social Security # _____ D.O.B. _____

Who is responsible for scheduling?

Name _____ Address _____

Home Phone _____ Work Phone _____

Social Security # _____ D.O.B. _____

Married _____ Single _____ Divorced _____ Separated _____ Widowed _____

Do you have orthodontic insurance? Yes / No

Insurance Co: _____ Phone # _____

Address: _____

Subscriber Name: _____ ID # _____

Employer: _____ Group # _____

What specifically brings you to our office? _____

Have you previously seen an orthodontist? Yes / No

If yes, what was the outcome? _____

Do you have?

Extra / Missing Teeth Yes / No
Teeth that have been extracted Yes / No

If yes, please explain: _____

Did you or do you do any of the following:

Clench or Grind teeth Yes / No
Suck thumb Yes / No
Breath with mouth open Yes / No
Brush Daily Yes / No
Floss Daily Yes / No

Have you had any of the following?

Yes / No	Abnormal Bleeding	Yes / No	Diabetes
Yes / No	Drug Allergies	Yes / No	Hearing Impaired
Yes / No	Allergic to latex	Yes / No	Heart Murmur
Yes / No	Allergic to plastic	Yes / No	Hemophilia
Yes / No	Hospital stays	Yes / No	Hepatitis
Yes / No	Operations	Yes / No	HIV &/ Aids
Yes / No	Asthma	Yes / No	Kidney/liver problems
Yes / No	Tuberculosis (TB)	Yes / No	Cancer
Yes / No	Rheumatic Fever	Yes / No	Scarlet Fever
Yes / No	Congenital Heart Defect	Yes / No	Convulsions / Epilepsy

If yes, please explain: _____

Do you take any medication on a daily basis? Yes / No

If yes what? _____

Physician's Name and Address: _____

Is there anything else we should know about you that we have not covered?

If yes, please explain: _____

The above is true and accurate to the best of my knowledge. I also authorize any insurance benefits to be paid directly to the dentist

Signature of patient or legal guardian

Date