IVERSON
ORTHODONTICS
A PERFECT FIT FOR YOUR TEETH

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WELCOME!

We want to welcome you to our orthodontic practice. We are looking forward to an enjoyable partnership which will result in healthier teeth and a sensational smile. Before we begin, we ask that you fill out this form in ink as completely as you can. Please print. Thank you.

Patient Information - Adult

Full Name_______________________________________ I prefer to be called______________________

Marital Status (Please circle one) Single Married Separated Divorced Widowed

Address ____

Age_____ Date of Birth________________ Gender M / F Social Security #________________________

Home Phone__________________ Work Phone____________________ Cell Phone________________

Referred to our office by____

Financially Responsible Party Information

Full Name_______________________________________ Relationship to Patient_________________

Address____ # Years at address _____

Home Phone___________________ Work Phone______________Cell Phone____________________

Email______________________ Social Security #__________________ Birthdate________________

Employer_____________________ Occupation___________________ No. Years Employed________

Other Responsible Party__________________________________ Relationship to Patient_________

Employer_____________________ Occupation___________________ No. Years Employed________

Email______________________ Social Security #__________________ Birthdate________________

Home Phone___________________ Work Phone______________Cell Phone____________________

Dental Insurance Information

Policy Holder's Name______________________________ Employer___________________________

Insurance Company__________________________ Group No.__________ Policy Number.______

Insurance Co. Address___________________________________ Insurance Co. Phone_____________

Policy Holder's Date of Birth________________________________ S.S.N.____________________

Emergency Contact Information

Name of nearest relative not living with you____

Complete Address____

Phone________________________ Relationship:_______________________________

Patient Medical History

Physician's Name________________________________ Office Phone__________________

How would you describe your current health? ___Excellent ___Good ___Fair ___Poor

Are you currently under a doctor's care? ___Yes ___No If yes, for what?__________________

Are you currently taking any medications? ___Yes ___No If yes, please list__________________

Do you have any allergies to medications or latex? ___Yes ___No If yes, please list__________________

Are you taking bone density medications? ___Yes ___No

Do you have a history of any of the following? Please check all that apply.

- ☐ Allergies
- ☐ Anemia
- ☐ Asthma
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Drug/Alcohol Abuse
- ☐ Epilepsy
- ☐ Fainting
- ☐ Hearing Problems
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Hemophilia
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Nervous/Anxious
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Thyroid Disease
- ☐ Tuberculosis

Please list any other medical conditions not addressed above. ________________________________

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Patient Dental History

Dentist's Name________________________________ Date of last visit__________________

Have you ever had an unfavorable experience with previous dental care? ___Yes ___No

Have you been evaluated for or had orthodontic treatment before? ___Yes ___No

If you answered yes to the above, please explain________________________________

What are the primary concerns and final objectives expected from orthodontic treatment? __________________

____

Do you have a history of any of the following? Please check all that apply and give details below.

- ☐ Injuries to face, mouth or teeth
- ☐ Pain or tenderness in jaw
- ☐ Missing or extra permanent teeth
- ☐ Speech problems
- ☐ Tonsils removed
- ☐ Play musical instruments by mouth
- ☐ Thumb/Finger sucking
- ☐ Tongue Thrust
- ☐ Mouth breathing
- ☐ Nail/Lip Biting
- ☐ Clenching/Grinding Teeth

Details: ____

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Authorization and Release

Please Initial And Sign

_____ In accordance with HIPAA regulations, I understand that this information will be held in strict confidence. I hereby give my permission for the office of Iverson Orthodontics to use patient records for diagnosis, treatment, promotion, and education.

_____I authorize Dr. Iverson to release any information necessary for insurance purposes and authorize direct payment of insurance benefits to Dr. Iverson for services rendered.

Signature ________________________________ Date__________________