MPOWERED SMILES
ORTHODONTICS

PATIENT INFORMATION

Date_____

Patient's name _____
Last First Middle

Address _____
Street City Zip

Nickname_____ Birthdate_____ Social Security # _____

School _____ Sports/Hobbies _____

Parent(s) or guardian(s) name _____

Whom may we thank for referring you to our office? _____

Please list name of any friends or family current in the practice: _____

RESPONSIBLE PARTY INFORMATION

Name _____
Last First Middle

Check this box if address is the same as patient's address ☐

Address _____
Street City Zip

Social Security #_____ Birthdate_____ Relationship to Patient _____

How long at this address?_____ Home phone_____ Work phone _____

Cell/other phone_____ Email address _____

Employer_____ Occupation_____ No. years employed _____

Significant Other Name_____ Relationship to Patient _____

Employer_____ Occupation_____ No. years employed _____

Social Security #_____Birthdate _____Work Phone_____

DENTAL INSURANCE INFORMATION

Insured's Name_____ Insured's Social Security #/Member ID Number _____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No._____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_____ Insured's Social Security #/ID Number_____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No._____

EMERGENCY INFORMATION

Name of nearest relative not living with you_____

Complete address_____
Street City Zip

Phone _____

RELEASE

I authorize release of any information regarding my or my child's orthodontic treatment to the dental and/or medical insurance company.

Signature _____Date _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____

Please circle Yes or No (If Yes, please fill in details)

Yes No Is the patient taking any medication? _____
Yes No Is the patient allergic to any medication? _____
Yes No Does the patient require antibiotic pre-medication before any dental procedures? _____
Yes No Does the patient have any known allergies (e.g. latex, metal, etc.) _____
Yes No History of a major illness? _____
Yes No Has the patient had any operations? _____
Yes No Ever been involved in a serious accident? _____
Yes No Have seen a physician in the last 12 months? Why? _____
Female Patients only:
Yes No Has menstruation started? _____
Yes No Is the patient pregnant? _____

Circle any of the medical conditions below that the patient has had or currently has.

ADD or ADHD	Congenital Heart Defect	Heart Murmur	Nervous Disorders
Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Radiation/Chemotherapy
Arthritis	Epilepsy	High Blood Pressure	Rheumatic Fever
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Tuberculosis
Bone Disorders	Heart Problems	Kidney problems	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

DENTAL HISTORY

General Dentist _____ Date of last visit _____
What is the patient's main orthodontic concern? _____
What is the patient's attitude toward receiving orthodontic treatment? _____

Please circle Yes or No (If Yes, please fill in details)

Yes No Has the patient ever seen an orthodontist? If yes, who and when? _____
Yes No Has anyone in the family received orthodontic treatment? _____
Yes No Is the patient sensitive or self-conscious about his/her teeth? _____
Yes No Speech problems/therapy? _____
Yes No Oral habits (thumb/finger sucking, tongue trust, lip/nail biting, etc.)? _____
Yes No Mouth breather? _____
Yes No Grind/clench teeth? _____
Yes No Snores during sleep? _____
Yes No Teeth or jaws ever feel uncomfortable first thing in the morning? _____
Yes No Experience jaw clicking or popping? _____
Yes No Experience "tension" headaches? _____
Yes No Injury to face, jaw, teeth, or mouth? _____
Yes No Has the patient ever lost or chipped any permanent teeth? _____
Yes No Any missing or extra permanent teeth? _____
Yes No Is the patient presently in any dental pain? _____
Yes No Ever experienced any unfavorable reaction to dentistry? _____
Yes No Do gums bleed when brushing? _____
Yes No Does the patient need extra help with instructions? _____

Are there any dental conditions we have not discussed that you feel we should be aware of? _____
_____

Yes No Are you aware that some appointments will be during school/work hours? _____

WAIVER

I have read the above questions and understand them. I have truthfully answered all the above questions and agree to inform MPowered Smiles Orthodontics PC and Dr. Milena Bulic of any changes in my/my child's medical or dental history. I will not hold my orthodontist or any member of her staff responsible for any errors or omissions that I have made in completion of this form.

Signature _____ Date _____