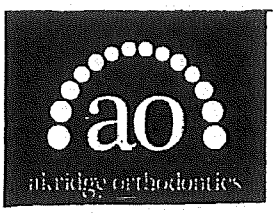
Records date_____



START date_____

Welcome! Our specialty is creating smiles and to do this we treat people, not just teeth. We care about your total health and appreciate your time in completing this information sheet.

Patient's name: _____

Responsible Party's Email _____

Patient's Address: _____ City _____ Zip_____

Birthdate: _____ Age: _____ Sex: _____ Telephone: _____

School/Employer: _____ Grade/Position: _____

Interest/Sports _____

Names and ages of siblings: _____

Primary

☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other (specify) _____ Telephone:

Responsible Party: _____ Cell phone: _____

Address: _____ How Long? _____

Employer: _____ Telephone: _____

Secondary

☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other (specify) _____ Telephone:

Responsible Party: _____ Cell phone: _____

Address: _____ How Long? _____

Employer: _____ Telephone: _____

Referral Information

How Did You Hear About Us? ☐ Dentist ☐ Patient ☐ Relative ☐ Acquaintance ☐ Other

Whom May We Thank For Referring You To Us? _____

Insurance Information *(Please fill out completely so we may properly file your insurance)*

Name of Primary Orthodontic Insurance: _____ Telephone: _____

Name of Policy Holder: _____ ☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other (specify) _____

Policy Holder's Birthdate: _____ Policy Holder's Social Security Number: _____

Name of Secondary Orthodontic Insurance: _____ Telephone: _____

Name of Policy Holder: _____ ☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other (specify) _____

Policy Holder's Birthdate: _____ Policy Holder's Social Security Number: _____

Emergency Information (Name of person to contact in case of an emergency)

Name: _____ Phone: _____

Relationship to patient: _____

Medical and Dental History

Name of physician: _____
Current medications? _____
History of a major illness? _____
Major operations? _____
Serious accident? _____
Have tonsils and/or adenoids been removed? Yes☐ No☐
Adolescent females – have you started menstruation? Yes☐ No☐ Adolescent males – has your voice changed? Yes☐ No☐

Circle Yes or No for which the patient has/had a history: **Is pre-medication needed for dental procedures? Yes No**

Aids/HIV	☐Y N☐	Cancer	☐Y N☐	Endocrine problems	☐Y N☐	Immune problems	☐Y N☐	Pneumonia	☐Y N☐	Tooth Grinding	☐Y N☐
Allergies (explain below)	☐Y N☐	Cerebral palsy	☐Y N☐	Emotional disorders	☐Y N☐	Kidney problems	☐Y N☐	Pregnant	☐Y N☐	Tuberculosis	☐Y N☐
Anemia	☐Y N☐	Chest pains	☐Y N☐	Epilepsy	☐Y N☐	Low Blood Pressure	☐Y N☐	Prolonged Bleeding	☐Y N☐	Venereal Disease	☐Y N☐
Arthritis	☐Y N☐	Chronic neck pain	☐Y N☐	Fainting, Dizziness	☐Y N☐	Mouth breathing	☐Y N☐	Rheumatic Fever	☐Y N☐		
Aspirin	☐Y N☐	Clicking of jaw	☐Y N☐	Glaucoma	☐Y N☐	Muscular disorders	☐Y N☐	Scoliosis	☐Y N☐		
Asthma	☐Y N☐	Cold Sores/Herpes	☐Y N☐	Headaches	☐Y N☐	Nervous Disorders	☐Y N☐	Seizures	☐Y N☐		
Autoimmune	☐Y N☐	Diabetes	☐Y N☐	Heart condition	☐Y N☐	Organ Transplant	☐Y N☐	Sicca	☐Y N☐		
Bone Disorders	☐Y N☐	Downs Syndrome	☐Y N☐	Hepatitis/Liver prob.	☐Y N☐	Painful chewing	☐Y N☐	Speech problems	☐Y N☐		
Bulimia	☐Y N☐	Drug allergies	☐Y N☐	High Blood Pressure	☐Y N☐	Periodontal problems	☐Y N☐	TMJ problems	☐Y N☐		

Are there any medical conditions, allergies, problems we have not discussed that you feel we should be aware of? Yes No

Name of dentist or dental practice: _____, _____ Date of last cleaning: _____

Reason for consultation and your concerns about your teeth: _____

HIPPA
ACKNOWLEDGEMENT OF NOTICE FOR PRIVACY PRACTICES

I, _____ can receive a copy of the HIPPA Notice of Privacy Practices which hangs on the wall in Dr. Akridges' waiting room.

Patients name _____

Parent or Guardian's name _____

Date _____

YES☐ NO☐ **Are you aware that some appointments will be during school/work hours?**

Benefits of Orthodontics

Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment.

I hereby state that I have read and understand the above paragraph. I have truthfully answered all of the above questions and agree to inform this office of any changes in medical or dental history.

Signature: _____ Relationship To Patient: _____ Date: _____