New Patient Form

WELCOME

TRIMMELL & ANDERS ORTHODONTICS

DATE:_____

Responsible Party Information- Confidential

Full Name _____ Marital Status_____
Last First Middle

Residence_____ ☐ Own ☐ Rent
Street City State Zip

Mailing Address_____ Email _____
Street City State Zip

How long at this address_____ Previous Address_____
(if less than 3 years) Street City State Zip

Home Phone_____ Work Phone_____ Cell Phone_____

Social Security#_____ Birthdate_____ Relationship to Patient _____

Employer _____ Occupation_____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer_____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____ Cell Phone _____

Patient Information - Confidential

Patient's Full Name _____ Male/ Female_____
Last First Middle

Address _____
Street City State Zip

Home Phone_____ Birthdate _____ Age_____Social Security # _____

If patient is a minor, give parent's or guardian's name _____School_____

Patient's General Dentist _____ Whom may we thank for referring you to our office? _____

Have we seen anyone else in your family before? _____ If yes, please list: _____

Emergency Contact _____ Address/Phone #_____

Email address for on-line access and appointment reminders via email:_____

Dental Insurance Information (Not Medical Insurance)

Subscriber's Name: _____Subscriber's Birth Date: _____ Subscriber's SS# _____

Employer/Group Name:_____ Subscriber's ID No. _____Relationship to Patient:_____

Subscriber's Home Address:_____Subscriber's Phone:_____

Insurance Company _____Insurance Phone # _____

Insurance Co. Address_____Group No. _____

Do you have dual coverage? (SECONDARY INSURANCE) ☐ NO ☐ YES If so:

Subscriber's Name: _____Subscriber's Birth Date: _____ Subscriber's SS# _____

Employer/Group Name:_____ Subscriber's ID No. _____Relationship to Patient:_____

Subscriber's Home Address:_____Subscriber's Phone:_____

Insurance Company _____Insurance Phone # _____

Insurance Co. Address _____Group No. _____

I understand that where appropriate, credit bureau reports will be obtained. I authorize Trimmell & Anders Orthodontics to perform an examination & x-rays for treatment. I certify that the information on this form is complete and true to the best of my knowledge.

Signature (Parent's signature if minor)_____ Print Name_____Date_____

(TURN OVER)

Patient Medical Information

Does patient have a speech problem and if so, receiving speech therapy? ☐ NO ☐ YES
Has patient had their tonsils or adenoids removed? ☐ NO ☐ YES
Is patient presently under the care of a physician or taking medication? ☐ NO ☐ YES Patient's Physician: Dr. _____
If so, what? _____
Has patient ever had an unusual reaction to any drug? ☐ NO ☐ YES If so, what?
_____
Does patient require medication prior to any dental procedure? NO YES If so, why? _____
Has patient had any of the following?

[1] Arthritis	[10] Diabetes	[19] Major surgery	[26] Osteoporosis
[2] Anemia	[11] Frequent colds	[20] Tuberculosis	[27] Taking Bisphosphonates?
[3] Bleeding problem	[12] Asthma	[21] Heart trouble	
[4] Epilepsy/Seizures	[13] Rheumatic Fever	[22] Thyroid or Hormonal imbalance	
[5] Nervous disorder	[14] Immune Deficiency	[23] Any other serious medical problems?	
[6] Hyperactivity	[15] Ulcers	[24] Have you ever had a concussion? NO YES	
[7] Hepatitis	[16] Herpes/Oral-facial	[25] Are you active in sports? NO YES	
[8] Venereal disease	[17] Allergies/Sinus	If so, what sports? _____	
[9] LATEX ALLERGY	[18] METAL/NICKEL ALLERGY		

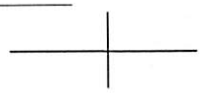
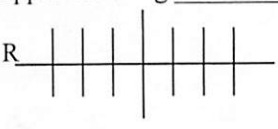
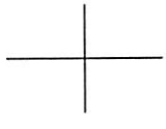
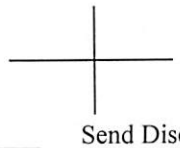
PLEASE CHECK ALL THAT APPLY:

Prosthetic cardiac valve or prosthetic material used for cardiac valve repair.
Previous infective endocarditis.
Congenital heart disease (CHD) & unrepaired cyanotic CHD, including palliative shunts & conduits; completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter intervention, during the first 6 months after the procedure; & repaired CHD with residual defects at the site or adjacent to the site of a prosthetic patch or prosthetic device.
Cardiac transplant recipients who develop cardiac valvulopathy.

Patient Dental History

Patient's General Dentist: Dr. _____
Does the patient presently suck their thumb or fingers? NO YES
Does the patient breathe mostly through the mouth? NO YES
Does the patient snore often? NO YES
Has the patient ever received a severe blow resulting in injury to the teeth or jaws? NO YES
If yes, please write in details _____
Does the patient grind their teeth at night? NO YES
In the past, has the patient ever complained of (please circle) clicking popping stiffness soreness in the jaw or muscles of the mouth?
Episodes when the jaw would not open or close normally? NO YES
Pain or discomfort in the front of the ear? NO YES
Headaches, neck and or back pain? NO YES
If yes, please write date and details _____
Has patient ever had orthodontic treatment or worn a retainer before? NO YES
Would patient object to wearing orthodontic appliances/braces should they be indicated? NO YES
What is patient's or parents' primary concern? _____

OFFICE USE ONLY

HIPAA CONSENT SIGNED
Date: _____ Patient name: _____ Adult present: _____
Records: Pano _____ Ceph _____ Pics _____ Model# _____
Diagnosis:
Class_____ OJ_____ OB_____ X-Bite  Buccal / Anterior
Upper spacing _____mm Lower spacing _____ mm
Upper crowding _____mm Lower crowding _____mm
Midline R  L Missing teeth  Impacted  Extractions 
EXBO/SURGERY: _____ Surgeon: _____ Send Disc
Notes: _____
_____
_____
Tx Plan: OBS1 OBS2 OBS3 OBS4 Limited Tx-Up/Lo ULA/LLA Ph 1 Full Tx -HERB RPE APP_____ Full Tx w/surgery Invisalign
1st Insurance Benefit: _____ pd @ _____ % 2nd Insurance Benefit: _____pd @ _____ %
Est Tx Time_____mos Dis: _____ICFD_____FAM_____PRO_____COUR_____ PIF