WELCOME

To the office of Dr. Miriam Van Allen

The benefits of a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset.

Please fill out this form completely. The more information we have, the better we can communicate with you. The better we communicate with you, the better we can care for you.

About You

Today's Date: _____

Name: _____
Last First M.I.

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate:___/___/___ Age:____SS#:_____

Home Address:_____

_____
City State Zip

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm#:(___)_____Cell#: (___)_____

Wk#:(___)_____Ext:____DL#: _____

Best # to reach you during the day: _____

E-Mail: _____

Employer: _____

Employers Address: _____

Occupation:_____How long: ____

Whom may we Thank for referring you?:_____

Other family members seen by us: _____

General Dentist: _____

Last Visit to Dentist: _____

Spouse Information

His / Her Name: _____

Employer: _____

Wk#: (___)_____Ext:____SS#:_____

Birthdate: ___/___/_____

Person Responsible for Account: _____

Wk#: (___)_____Ext:___Hm#:(___)_____

Billing Address: _____

_____
City State Zip

Relation:_____SS#: _____

Employer:_____DL#:_____

Orthodontic Insurance

Primary

Orthodontic Coverage: ☐Yes ☐ No Dental Coverage: ☐Yes ☐No

Insurance Co. Name:_____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # :_____

Insured's Name: _____Relation:_____

Insured's Birthdate: ___/___/____ Insured's SS #: _____

Insured's Employer: _____

Secondary

Orthodontic Coverage: ☐Yes ☐ No Dental Coverage: ☐Yes ☐No

Insurance Co. Name:_____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # :_____

Insured's Name: _____Relation:_____

Insured's Birthdate: ___/___/____ Insured's SS #: _____

Insured's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: _____Relation: _____

Wk #: (____)_____Hm #: (____)_____

Medical History

Do you have a personal physician: ☐ Yes ☐ No

Physician's Name:_____

Phone #: (____)_____

Date of last visit: _____

(Please continue on page 2…)

Medical History – *continued*

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician: ☐ Yes ☐ No

Please explain:_____

Are you taking any prescription / over-the-counter drugs: ☐ Yes ☐ No

Please list each one: _____

_____

Are you taking a Bisphosphonate such as Fosamax: ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No **Week #:** _____

Have you ever had any of the following diseases or medical problems?

Y N	Abnormal bleeding	Y N	Heart Surgery / Pacemaker
Y N	Anemia	Y N	Hemophilia
Y N	Artificial bones / Joints / Valves	Y N	Hepatitis
Y N	Arthritis	Y N	High/Low Blood Pressure
Y N	Asthma	Y N	HIV+ / AIDS
Y N	Blood Transfusion	Y N	Hospitalized for any reason
Y N	Cancer / Chemotherapy	Y N	Kidney Problems
Y N	Congenital Heart Defect	Y N	Mitral Valve Prolapse
Y N	Diabetes	Y N	Psychiatric Problems
Y N	Difficulty Breathing	Y N	Radiation Treatment
Y N	Drug / Alcohol Abuse	Y N	Rheumatic / Scarlet Fever
Y N	Emphysema	Y N	Severe/ Frequent Headaches
Y N	Epilepsy / Seisures / Fainting	Y N	Shingles
Y N	Fever Blisters / Herpes	Y N	Sinus Problems
Y N	Glaucoma	Y N	Tuberculosis (TB)
Y N	Heart Attack / Stroke	Y N	Ulcers / Colitis
Y N	Heart Murmur	Y N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

Are you allergic to any of the following?

Y N	Aspirin	Y N	Dental Anesthetics	Y N	Penicillin
Y N	Any Metals/Plastics	Y N	Erythromycin	Y N	Tetracycline
Y N	Codeine	Y N	Latex	Y N	Other

Please list any other drugs / materials that you are allergic to: _____

_____

Dental History

What are the main concerns that you would like orthodontics to accomplish?

_____

_____

Have you ever had or been evaluated for orthodontic treatment: ☐Yes ☐No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐Yes ☐No

Do you now or have you ever experienced pain / Discomfort in your jaw joint (TMJ / TMD)? ☐Yes ☐No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐Yes ☐No Gums ever bleed? ☐Yes ☐No

Have you ever had an injury to your: Mouth Teeth Chin (please circle)

Do you have any speech problems? _____

Do you generally breathe through your mouth? ☐Yes ☐No
If yes, please circle: While Awake? While Asleep?

Do you have any missing or extra permanent teeth? ☐Yes ☐No

Do you smoke or use tobacco in **any** form? ☐Yes ☐No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____
Signature **Date**

Thank you for filling out this form completely.

This office reserves the right to verify the credit status of potential patients and / or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

_____
Signature **Date**

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

_____
Signature **Date**

Office Use Only OFFICE USE ONLY Office Use Only OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient herein. Initials: _____Date: _____
Doctor's Comments: _____

_____

_____

_____

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC & the ADA