Bocklet Orthodontics™
YOUR SMILE IS OUR FOCUS

PATIENT INFORMATION			
Last Name:	First:		Middle:
Preferred Name:	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.	Birth Date: / /	Age:
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other			
Social Security Number:		Sex: ☐ M ☐ F	
Email:		Phone Number:	
Home Address:			
City:	State:	Zip Code:	
Emergency Contact: (First and Last name)			
Relation:	***Phone Number:***		
General Information			
Who may we thank for referring you?			
General Dentist:	Last cleaning date:		
Dentist's Phone Number:	Any other dental work planned:		
****Other family members in treatment at Bocklet Orthodontics:***			
Would you like to receive notifications about appointments through Text / Email / Call (circle form of communication)? ☐ Yes ☐ No			
Responsible Party			
Who is responsible for the account: (Same as above) ☐ Yes ☐ No			
Person responsible for account : (first and last name)			
Relation to responsible party: ☐ Father ☐ Mother ☐ Grandparent ☐ Self ☐Other _____			
Address:			
City:	State:	Zip Code:	
Email:	Phone Number:		
Responsible party employer:	Occupation:		
Work phone Number:			

INSURANCE INFORMATION

(if you have orthodontic insurance please fill out)

If you have **ORTHODONTIC** Insurance Coverage please fill out below:			If you have **Secondary ORTHODONTIC** Insurance Coverage Please fill out below:		
Employer:			Employer:		
Occupation:	Work #:		Occupation:	Work #:	
City:	State:	Zip:	City:	State:	Zip:
Insurance Company:			Insurance Company:		
Insurance Address:			Insurance Address:		
City:	State:	Zip:	City:	State:	Zip:
Insurance Phone Number:			Insurance Phone Number:		
Group number:			Group Number:		
ID #:			ID #:		
Policy Holder:			Policy Holder:		
Policy Holder DOB: / /			Policy Holder DOB: / /		
Policy Holder Social Security Number:			Policy Holder Social Security Number:		
Relation to policy holder:			Relation to policy holder:		

AUTHORIZATION

NOTICE: Payment is due in full at time of treatment, unless the Financial Coordinator has approved prior arrangements. I understand that I am responsible for payment of services rendered and also responsible for paying deductibles that my insurance does not cover. I authorize payment of my group insurance benefits to be made directly to this office. I understand that I am responsible for all cost of orthodontic treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examinations, to my insurance company.

Signature of Patient:	*Date:*

** DO YOU NEED PRE-MED FOR DENTAL CLEANINGS: ☐ YES ☐ NO **

MEDICAL HISTORY

Do you have personal physician? ☐ Yes ☐ No

Physician's name:

Physician's Phone Number:

Current physical health: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician?
☐ Yes ☐ No
If yes, explain:

Do you smoke or use tobacco products of any kind?
☐ Yes ☐ No

Have you had any metal rods, pins, or implants?
☐ Yes ☐ No
If yes, explain:

Are you taking any prescription/over-the-counter drugs?
☐ Yes ☐ No
Please list each one: _____
_____

Have you ever taken a Bisphosphonate for Osteoporosis such as Bonivia, Fosamax, Actonel, Skelid, or Zometa? ☐ Yes ☐ No
If yes for how long?

Have you ever taken Phen-Fen? Also known as Redux or Pondimin.
☐ Yes ☐ No If yes, when:

FOR WOMEN:
Are you taking birth control pills? ☐ Yes ☐ No
Are you pregnant? Week(s): ____ ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems (mark with an X for any that are YES)

___Abnormal Bleeding / Hemophilia
___AIDS
___Anemia
___Arthritis
___Artificial bones/joints/valves
___Asthma
___Blood Transfusion
___Cancer /Chemotherapy
___Congenital Heart Defect
___Diabetes
___Difficulty breathing
___Emphysema
___Epilepsy
___Fainting Spells
___Frequent Headaches
___Glaucoma
___Hay Fever
___Heart Attack / Surgery
___Heart Murmur
___Hepatitis
___Herpes / Fever Blisters
___High Blood Pressure
___HIV
___Hospitalized for any reason
___Kidney Problems
___Liver Disease
___Low Blood Pressure
___Lupus
___Mitral Valve Prolapse
___Pacemaker
___Psychiatric Problems
___Radiation Treatment
___Rheumatic / Scarlet Fever
___Seizures
___Shingles
___Sickle Cell Disease / Traits
___Sinus Problem
___Stroke
___Thyroid Problems
___Tuberculosis (TB)
___Ulcers
___Venereal Disease

If you marked any of the above please explain: _____
_____
_____

Are you allergic to any of the following? (Mark with an X for any that are YES)

___Aspirin
___Codeine
___Dental Anesthetics
___Erythromycin
___Penicillin
___Tetracycline
___Jewelry/Metals
___Latex
___Other

Please List any other drugs / materials you are allergic to:

DENTAL HISTORY

What are the main ORTHODONTIC concerns that you have? _____
_____

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 or discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

If yes, for how long? _____

Popping? ☐ Yes ☐ No Clenching? ☐ Yes ☐ No
Clicking? ☐ Yes ☐ No Grinding? ☐ Yes ☐ No
Eating issues? ☐ Yes ☐ No

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

Have you ever had an injury to your:
☐ Mouth ☐ Teeth ☐ Chin
If so please explain:_____
_____

Do you have any speech problems? ☐ Yes ☐ No

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

Are you happy with the way your smile looks?
☐ Yes ☐ No
If no, what would you change?_____
_____

Do/ did you have any of the following habits?
(Mark with an X for any that are YES)

__Nail Biting
__Tongue Thrust
__Lip Sucking/ Biting
__Thumb/ Finger Sucking
__Used Pacifier

I understand that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and that 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. 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. Also at the discretion of the office, use the services of one or more credit reporting services.

_____
Signature *Date*

OFFICE USE ONLY

I verbally reviewed the medical and dental information with this patient.
Initials: _____ Date:_____

Doctor's Comments:
_____
_____
_____