BILLY POWELL ORTHODONTICS

Patient Information

Today's Date _____

Patient's Full Name _____
Resident Address _____
City _____ State _____ Zip _____
Mailing address (if different) _____
_____
Home Phone _____
Cell Phone _____
Work Phone _____
Employer _____
Email Address _____
Date of Birth _____ Age _____
Sex Male Female
Marital Status Married Single Divorced Separated
Hobbies/Interests _____
Whom may we thank for referring you to our office? _____

Dentist _____ Dental Group _____
Address _____
Phone # _____
Date of last dental exam _____

Spouses Name _____
Employer _____ Work # _____
Email Address _____

Insurance Information
Primary

Dental Insurance Name _____
Insured Person _____
Social Security # _____ DOB _____
Employer _____
Insurance Address _____
City _____ State _____ Zip _____
Insurance Phone # _____ Group # _____

Secondary

Dental Insurance Name _____
Insured Person _____
Social Security # _____ DOB _____
Employer _____
Insurance Address _____
City _____ State _____ Zip _____
Insurance Phone # _____ Group # _____

Please Turn Over For More Information

Health Questionnaire

Name of Physician _____

Date of last exam _____

Do you have or use any of the following (indicate with an "x"):

____Teeth sensitive to cold, heat, sweets, or pressure
____Food Impaction
____Burning of Tongue
____Frequent blisters on lips or mouth
____Unusual sounds in ear while eating
____Unpleasant taste
____Complications from extractions
____Orthodontic treatment
____Oral habits (fingernail biting, cheek biting)
____Frequency of brushing _____x a day
____Water jet device
____Bleeding Gums
____Clenching or grinding teeth
____Swelling or lumps in mouth
____Pain around ear
____Bad Breath
____Unfavorable dental experience
____Periodontal treatment
____Mouth breathing
____Cigarettes, pipe or cigar smoking
____Dental Floss
____Fluoride supplements

Medical History

____Allergies to drugs
____Any heart ailments
____Excessive bleeding
____Asthma
____Kidney problems
____Psychiatric/emotional care
____Stroke
____Eye Disorders
____Tuberculosis
____Venereal disease
____Allergies to anesthetics
____Neurological disorders
____Anemia/blood problems
____Hay fever/allergies
____Liver problems/hepatitis
____Rheumatic fever
____Thyroid disorders
____Tonsillitis
____Ulcer or colitis
____Injuries to the mouth/jaw
____High Blood Pressure
____Radiation treatments
____Arthritis
____Diabetes
____Malignancies
____Sinus problems
____Immune System Disorders (HIV, AIDS)
____Tuberculosis
____Pregnancy, if so, what month _____
____Recurrent headaches, if so, location:
____Front ____Back of head ____Side

Describe any current medical treatment including drugs taking, including those not listed above:

_____

_____

_____

Signature of responsible party_____Date_____