Welcome

MC ORTHODONTICS

Thank you for selecting us. Please complete all applicable fields in ink.

01 PATIENT INFORMATION

Patient name

Patient number (office use)

Date

Birthdate

SSN / SIN

Street address

City

State / Province

ZIP / Postal code

Email

Home phone

Cell phone

Work phone

Check appropriate boxes ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If student: school / college

City

State / Province

☐ Full time ☐ Part time

Patient or parent / guardian employer

Business address

Employer city

State / Province

ZIP / Postal code

Spouse or parent / guardian name

Employer

Whom may we thank for referring you?

Emergency contact name

Emergency contact phone

Billing & insurance

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Complete the responsible party and insurance sections that apply.

02 RESPONSIBLE PARTY

Name of person responsible for this account

Relationship to patient

Address

Home phone

Email

Cell phone

Driver's license number

Birthdate

Financial institution

Employer

Work phone

SSN / SIN

Is this person currently a patient in our office? ☐ Yes ☐ No

Preferred payment method (payment in full at each appointment):

☐ Cash ☐ Personal check ☐ VISA ☐ MasterCard

☐ I wish to discuss the office's payment policy.

03 PRIMARY INSURANCE

Name of insured

Relationship to patient

Birthdate

SSN / SIN

Date employed

Name of employer

Union or local #

Work phone

Employer address

City

State / Province

ZIP / Postal code

Insurance company

Group #

Policy / ID #

Insurance company address

City

State / Province

ZIP / Postal code

Deductible

Amount used

Maximum annual benefit

Insurance & medical history

MC ORTHODONTICS

Please check Yes or No for each question.

Do you have any additional insurance? ☐ Yes ☐ No

04 ADDITIONAL INSURANCE (IF APPLICABLE)

Name of insured

Relationship to patient

Birthdate

SSN / SIN

Date employed

Name of employer

Union or local #

Work phone

Employer address

City

State / Province

ZIP / Postal code

Insurance company

Group #

Policy / ID #

Insurance company address

City

State / Province

ZIP / Postal code

Deductible

Amount used

Maximum annual benefit

05 PATIENT MEDICAL HISTORY

Physician

Office phone

Date of last exam

1. Are you under medical treatment now? ☐ Yes ☐ No
2. Have you been hospitalized for surgery or a serious illness within the last 5 years? ☐ Yes ☐ No
3. Are you taking any medications, including non-prescription medicine? ☐ Yes ☐ No
4. Have you ever taken Fen-Phen / Redux? ☐ Yes ☐ No
5. Do you use tobacco? ☐ Yes ☐ No
6. Do you use controlled substances? ☐ Yes ☐ No
7. Do you wear contact lenses? ☐ Yes ☐ No

If yes to questions 2 or 3, please explain / list medications:

Medical history continued

Please check every applicable Yes or No response.

05 MEDICAL HISTORY (CONTINUED)

8. Do you have, or have you had, any of the following?

	Y	N		Y	N		Y	N
High blood pressure	☐	☐	Heart disease	☐	☐	Chest pains	☐	☐
Heart attack	☐	☐	Cardiac pacemaker	☐	☐	Easily winded	☐	☐
Rheumatic fever	☐	☐	Heart murmur	☐	☐	Stroke	☐	☐
Swollen ankles	☐	☐	Angina	☐	☐	Hay fever / allergies	☐	☐
Fainting / seizures	☐	☐	Frequently tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation therapy	☐	☐
Low blood pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / convulsions	☐	☐	Cancer	☐	☐	Recent weight loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver disease	☐	☐
Diabetes	☐	☐	Joint replacement / implant	☐	☐	Heart trouble	☐	☐
Kidney diseases	☐	☐	Hepatitis / jaundice	☐	☐	Respiratory problems	☐	☐
AIDS or HIV infection	☐	☐	Sexually transmitted disease	☐	☐	Mitral valve prolapse	☐	☐
Thyroid problems	☐	☐	Stomach trouble / ulcers	☐	☐	Other	☐	☐

9. Allergies / reactions

	Y	N		Y	N
Local anesthetics (e.g., Novocain)	☐	☐	Iodine	☐	☐
Penicillin or other antibiotics	☐	☐	Aspirin	☐	☐
Sulfa drugs	☐	☐	Metals (e.g., nickel, mercury)	☐	☐
Barbiturates	☐	☐	Latex rubber	☐	☐
Sedatives	☐	☐	Other	☐	☐

10. Persistent cough or throat clearing for over 3 weeks? ☐ Yes ☐ No

11. Women only: Are you pregnant or think you may be pregnant? ☐ Yes ☐ No

12. Women only: Are you nursing? ☐ Yes ☐ No

13. Women only: Are you taking oral contraceptives? ☐ Yes ☐ No

Dental history & authorization

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Please complete this section before signing.

06 PATIENT DENTAL HISTORY

Previous dentist and location

Date of last exam

1. Do your gums bleed while brushing or flossing?	☐ Yes	☐ No
2. Are your teeth sensitive to hot or cold liquids / foods?	☐ Yes	☐ No
3. Are your teeth sensitive to sweet or sour liquids / foods?	☐ Yes	☐ No
4. Do you feel pain in any of your teeth?	☐ Yes	☐ No
5. Do you have any sores or lumps in or near your mouth?	☐ Yes	☐ No
6. Have you had any head, neck or jaw injuries?	☐ Yes	☐ No
7. Have you experienced clicking, facial or joint pain, difficulty opening or closing, or difficulty chewing?	☐ Yes	☐ No
8. Do you have frequent headaches?	☐ Yes	☐ No
9. Do you clench or grind your teeth?	☐ Yes	☐ No
10. Do you bite your lips or cheeks frequently?	☐ Yes	☐ No
11. Have you ever had any difficult extractions?	☐ Yes	☐ No
12. Have you ever had prolonged bleeding following extractions?	☐ Yes	☐ No
13. Have you had any orthodontic treatment?	☐ Yes	☐ No
14. Do you wear dentures or partials?	☐ Yes	☐ No

If yes, date of denture / partial placement

15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐ Yes	☐ No
16. Do you like your smile?	☐ Yes	☐ No

Authorization & release

Please review the statement below and sign.

07 AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information, including the diagnosis and records of any treatment or examination rendered to me or my child during the period of dental care to third-party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient (or parent / guardian, if minor)

Date

OFFICE USE ONLY

Doctor’s comments

Doctor / staff signature

Date