BLUEWAVE ORTHODONTICS
Feldman • McDowell

www.BlueWaveOrtho.com

Member American Association of Orthodontists

Today's Date: _____

Patient's Legal Name: _____ Nickname: _____

Birthdate: ____/____/____ Age: _____ Sex: Male/ Female Marital Status : S/M/W/D School/Grade: _____

Home Address: _____

Email:_____

Home Phone #: (___)_____ Mobile Phone #: _____Mobile carrier:_____

Hobbies/Interest: _____ Siblings/Ages: _____

Emergency Contact
Name: _____ Relationship: _____ Phone: _____

RESPONSIBLE PARTY INFORMATION "REQUIRED"

Name: _____ Birthdate: _____/_____/_____ Relationship: _____

Billing Address: _____ How long at this address: _____

Employer: _____Cell/Work #: _____ Ext: _____How long: _____

Name: _____ Birthdate: _____/_____/_____ Relationship:_____

Billing Address:_____ _____

Employer: _____ Cell/Work #: _____ Ext: _____ How long:_____

GENERAL INFORMATION

General Dentist: _____ Last Visit Date: _____

Other Dental Specialists: _____

Whom May We Thank For Referring You? _____

Does anyone else in the family need orthodontics? Yes / No If Yes, who?_____

DENTAL INSURANCE

Primary
Ins. Co. Name: _____ Group #: _____

Ins. Co. Address:_____

Ins Co. Phone: (_____) _____Insured ID #: _____

Insured's Name: _____ Relation: _____ D.O.B:_____

Insured's Employer: _____

If there is a secondary insurance plan, please see front desk for an additional form so we can gather that additional information

MEDICAL HISTORY

Your current health is: Good ___Fair ___Poor
Do you have a personal physician? ___Y ___N
Physician's Name:_____
Phone #: (___)_____Date of last visit:_____
Are you currently under the care of a physician? ___Y ___N
Please explain:_____
Are you taking any prescription/over-the-counter drugs? __Y __N
Please list each one:_____
Are you pregnant? __ Y __ N

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

Y N Abnormal Bleeding
Y N Anemia
Y N Artificial Bones/Joints/Valves
Y N Asthma/Arthritis
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Diabetes
Y N Difficulty Breathing/Snoring
Y N Drug/Alcohol Abuse
Y N Emphysema
Y N Epilepsy/Seizures/Fainting
Y N Glaucoma

Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery/Pacemaker
Y N Hemophilia

Y N Hepatitis
Y N High/Low Blood Pressure
Y N HIV/AIDS
Y N Hospitalized for Any Reason
Y N Kidney Problems
Y N Mitral Valve Prolapse
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic/Scarlet Fever
Y N Severe/Frequent Headaches
Y N Shingles
Y N Sickle Cell Disease/Traits

Y N Tuberculosis (TB)
Y N Ulcers
Y N Colitis
Y N Venereal Disease

Are you allergic to any of the following?

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

Y N Penicillin
Y N Tetracycline
Y N Other
Please list any other drugs/materials you are allergic to:_____
_____

DENTAL HISTORY

What are the main concerns that you would like orthodontics to address?
_____
_____
Have you ever had or been evaluated for orthodontic treatment? ___Y__N
Have you ever had a problem associated with previous dental work? __Y __N
Have you ever experienced jaw joint pain/discomfort (TMJ/TMD)? ___Y __N

Your current dental health is: __Good__Fair__Poor
Do your gums ever bleed? ___Yes ___No
Have you ever had an injury to: ___Mouth___Teeth___Chin
Do you have any missing or extra permanent teeth? Y_N
Have you ever taken bisphosphonate? Y__N

Have you ever experienced any of the following?

Y N Clenching/Grinding Teeth
Y N Lip Sucking/Biting
Y N Mouth Breathing
Y N Nail Biting

Y N Pacifier
Y N Speech Problems
Y N Thumb/Finger Sucking
Y N Tongue Thrust

Sleep Behavior:

Do you snore? ___Y ___N
Do you grind your teeth during sleep? ___Y ___N
Do you seem tired during the day? ___Y ___N

INFORMATION & CONSENT

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

CONSENT TO THE USE OF RECORDS

I hereby give my permission for the use of orthodontic records, including photographs, made in the process of examinations, treatment and retention for purposes of professional consultations, research, education, publication in professional journals, scientific papers, demonstration or marketing purposes. In addition, when i-CAT images are taken, the orthodontist will interpret only those areas consistent with a 2D panorex or ceph. The patient is welcome to have these images further diagnosed by a radiologist for more details at their cost.

_____
Signature Date

THANK YOU FOR FILLING OUT THIS FORM COMPLETELY

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

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian of the patient named herein. Initials:_____Date:_____

Doctor's Comments:_____