Becker & Scott, DDS, LLC

Exceptional Orthodontics for Children & Adults

Date ________________

Patient's Name ____
Last First Middle Nickname

Address ____ Home Phone ________________
Street City & State Zip

How long at current address? _________ Previous address *(if less than 3 years)* ______________________
Street City & State Zip

Birthdate ____________ Age ______ Sex _______ Soc. Security # ____________________ Work Phone ________________

Employer ______________________________ Occupation ______________________________

Business address ______________________________ Number of years employed ____________

Spouse's Name ____________________ Employer ____________________ Soc. Security # ____________________

Orthodontic Insurance? _________ Insurance Company ____________________ Insurance Carrier ____________________

Family Dentist ____________________ Date of your last dental exam/cleaning ____________________

Physician ______________________________ Oral Surgeon ______________________________

Whom may we thank for referring you? ______________________________

Has anyone else in your family been treated in this office? _________ Name ______________________________

Has anyone in your family had braces? _________ If so, who? ______________________________

Was the result satisfactory? _________ If not, explain ______________________________

____

Hobbies or interests ______________________________

GENERAL HEALTH/MEDICAL HISTORY

How would you rate your overall health? ______________________________

Check any of the following for which you have been treated or diagnosed:

❏ Diabetes	❏ Tuberculosis	❏ Endocrine problems	❏ Bone disorders	❏ Immune deficiency
❏ Pneumonia	❏ Anemia	❏ Prolonged bleeding	❏ Kidney involvement	❏ Blood disorder
❏ Heart trouble	❏ Epilepsy	❏ Fainting or dizziness	❏ Liver involvement	❏ Thyroid
❏ Rheumatic fever	❏ Asthma	❏ Nervous disorders	❏ Hepatitis	❏ Excessive nervousness

Have your tonsils and adenoids been removed? _________ When? ______________________________

Have your wisdom teeth been removed? _________ When? ______________________________

Are you a mouth breather? ____________________ Do you have excessive headaches? ____________________

Are you currently taking or have you ever taken or been prescribed bisphosphonates? ❏ Yes ❏ No

List any allergies ______________________________

List any major or unusual illness or serious health problems ______________________________

____

Are you on medication? _________ Explain ______________________________

Do you object to braces? _________ Explain ______________________________

Has your dentist pointed to some orthodontic problem? _________ Explain ______________________________

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Has an orthodontist been consulted previously? ______________________________

What would you like to have orthodontic treatment accomplish? ______________________________

Mention any information which you feel may be helpful ______________________________

The policy in our office is: The person who requests treatment is responsible for all fees for services rendered. I understand that where appropriate, credit bureau reports may be obtained. I authorize the release of all X-rays related to the above named patient.

Signature ______________________________