

EPIC ORTHODONTICS

Dr. Joseph D. Hicks | Dr. Carli Loss

We would like to welcome you to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible.

Thank You!

PATIENT INFORMATION

Patient Name _____ Male Female
Social Security # _____ Birth Date _____ Driver License # _____
Home Address _____
City _____ State _____ Zip _____
Primary Phone # _____ home cell Ok to leave Message? Y N
Secondary Phone # _____ home cell other Ok to leave Message? Y N
Email _____
Employer's Name _____ Occupation _____

SPOUSE / EMERGENCY CONTACT INFORMATION

Marital Status Single Married Divorced Widowed Significant Other

Spouse / Partner's Name _____
Emergency Contact Name _____
Phone # _____ Relation to you _____
Address _____
City _____ State _____ Zip _____

Person(s) OK to release appointment or medically related information to concerning you.

_____ Relation(s) _____

DENTAL INSURANCE INFORMATION

Primary Insurance Company _____ Phone Number _____
Group # _____ Policy # _____ Member ID # _____
Policy Holder's Name _____ Relation _____
Policy Holder's Social Security # _____ Policy Holder's Birth Date _____
Employer _____ Work Phone # _____
Co-pay (if known) _____ Deductible (if known) _____

Secondary Insurance Company _____ Phone Number _____
Group # _____ Policy # _____ Member ID # _____
Policy Holder's Name _____ Relation _____
Policy Holder's Social Security # _____ Policy Holder's Birth Date _____
Employer _____ Work Phone # _____
Co-pay (if known) _____ Deductible (if known) _____

DENTAL HISTORY

General Dentist _____ Last Visit _____

How did you hear about our Practice?

Treated Family Member Ad Internet Family or Friend Physician Other

Name of person referring (if applicable) _____

What are the main concerns you would like orthodontics to accomplish?

Have you visited an orthodontist before? Y N

When? _____ Reason? _____

Have your tonsils or adenoids been removed? Y N

Have you ever experienced jaw joint pain/discomfort (TMJ/TMD) ? Y N

Do you have any missing or extra permanent teeth? Y N

Have you ever had an injury to (*select all that apply*): Teeth Mouth Chin

Do you have speech problems? Y N If so, explain _____

Do your gums bleed? Y N Do you smoke? Y N

Do you like your smile? Y N

Do you currently or have you ever had any of the following habits

(*check all that apply*)

Clenching/Grinding Teeth

Mouth Breathing

Thumb / Finger Sucking

Lip Sucking/Biting

Nail biting

Chewing / Eating Problem

MEDICAL HISTORY

Are you currently being treated by a physician? Y N Reason _____

Physician _____ Last Visit _____ Phone _____

Do you have any allergies/sensitivities to medications or latex? Y N

If yes, please list allergies.

Are you currently taking any prescription or over-the-counter medications? Y N

Please list, with dosage. _____

Have you had any serious illnesses or operations? If yes, describe:

Have you ever had a blood transfusion? Y N

If yes, give approximate dates: _____

(Women)

Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Check if you have or have ever had any of the following:

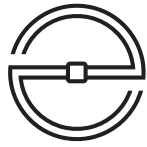
- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |

AUTHORIZATION

- ❖ 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 of confidence and it is my responsibility to inform the office of any changes in my medical status.
- ❖ I hereby authorize the release of any information pertaining to my medical treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payment of any benefits to the office. I understand that I am responsible for any amount not covered by insurance.
- ❖ I understand that where appropriate, credit bureau reports may be obtained.

Patient Signature and/or Responsible Party

Date



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Have you ever had a blood transfusion? Y N

If yes, give approximate dates: _____

(Women)

Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

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- | | | | |
|--|---|--|---|
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