WELCOME

We would like to welcome you to Edina Orthodontics Centennial Lakes! In an effort to provide the best service possible, we ask you to fill out this form as completely as possible.

Patient Information

First Name: _____ MI: _____ Last Name: _____ Date: _____

Birth Date: _____ Nickname: _____ Gender: Male Female

Home Address: _____ City: _____ State: _____ Zip:_____

Primary Phone #: _____ 2nd Phone #: _____ Email: _____

Mother/Guardian Information (if applicable)

First Name: _____ MI: ____ Last Name: _____ Phone #: _____

Father/Guardian Information (if applicable)

First Name: _____ MI: ____ Last Name: _____ Phone #: _____

Marital Status: Married Single Divorced Widowed Significant Other

Please list the names of any family members in our practice: _____

Dental Insurance Information

Primary Insurance

Policy Holder's Name: _____ Birth Date: _____ Employer: _____

Insurance Company: _____ Insurance Address: _____

Group #: _____ ID# :_____ Insurance Company Phone #: _____

Secondary Insurance

Policy Holder's Name: _____ Birth Date:_____ Employer: _____

Insurance Company: _____ Insurance Address: _____

Group #: _____ ID# :_____ Insurance Company Phone #: _____

Dental History

General Dentist:_____ Date of last exam (MM/YY): _____

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

Have you ever visited an orthodontist? Yes No If yes, for what reason? _____

Have you had a recent panoramic x-ray taken? Yes No If yes, when and where? _____

How did you hear about us? _____ Name of the person who referred you? _____

Dental History

Have you ever experienced jaw pain/discomfort? (TMJ/TMD) *Yes* *No* If so, when? _____

Do you have any extra or missing teeth? Yes No Do you have any speech problems? Yes No

Have you ever had an injury to any of the following? Chin Teeth Mouth If so, explain. _____

Do you have or have you had any of the following habits. Circle all that apply.

Clenching /Grinding teeth Mouth Breathing Nail Biting Lip sucking/Biting Thumb/finger Sucking Chewing/Problems

Medical History

Do you have any history of major illnesses? Yes No If Yes, explain. _____

Are you allergic to any medications, food or anything else? If yes, explain. _____

Are you currently taking any medications? If Yes, please list. _____

Do you need to be pre-medicated for appointments due to a medical condition? Yes No

Do you have or have you had any of the following conditions? Circle all that apply.

Abnormal bleeding AIDS or HIV positive ADHD/ADD Arthritis Asthma Autism Cancer

Cerebral Palsy Cleft Palate Diabetes Epilepsy/ Seizures Hearing Problems Heart Disease Heart Murmur

Hemophilia Hepatitis High or Low Blood Pressure Hospital Stays/Surgeries Kidney Problems Liver Problems

Osteoporosis /Osteopenia Speech/Breathing Problems Sickle Cell Anemia Tobacco Use Tuberculosis

Other : _____ Does your child have an ISP at school? (if applicable) Yes No

What is Important to you?

Please rate the following with 5 being the most important and 1 being the least

Comfort of treatment- 1 2 3 4 5

Clear or invisible treatment options- 1 2 3 4 5

Length of treatment- 1 2 3 4 5

Latest technology for treatment- 1 2 3 4 5

Low down payment- 1 2 3 4 5

Low monthly payments- 1 2 3 4 5

Starting treatment as soon as possible- 1 2 3 4 5

Signature

I understand that the information that I have provided is correct to the best of my knowledge. I agree to inform this practice of any changes in my medical or dental history. In addition, I authorize Edina Orthodontics to perform a complete orthodontic evaluation

Signature _____ Date _____