WELCOME TO DR. SCHECHTMAN'S
Orthodontic Office

Today's Date_____

Mr. Mrs. Ms. Dr.

Name:(L)_____(F)_____

I prefer to be called:_____ M F

Birth date____/____/_____ Age_____ SS#_____

Home Address:_____

_____# yrs there_____

City_____ Zip_____

[ ]Single [ ]Married [ ]Divorced [ ]Widowed [ ]Separated

Home# (____)_____ Cell#(____)_____

Wk# (____)_____Ext:_____DL#_____

Employer:_____

Employer's Address:_____

City:_____State:_____Zip:_____

How Long there?_____ Occupation:_____

Where & When are best times to reach you?_____

Whom may we Thank for referring you?_____

Other Family members seen by us:_____

Previous / Present Dentist:_____

Spouse Information

His / Her Name:_____

Employer:_____Occupation:_____
How long there?_____

Wk#:(___)_____Ext:_____Cell#:(____)_____

Birth date:_____/_____/_____ Age:_____ SS#:_____

Relative or Friend not living with you.

Name:_____ Relation:_____

Wk#:(____)_____Ext:____ Home#:(____)_____

Insurance

Orthodontic Coverage? [ ] Yes [ ] No

Primary

Insurance Co. Name:_____

Insurance Address:_____

City_____State_____Zip_____

Insurance Phone:(____)_____

Group#(Plan, Local, or Policy#):_____

Insured's Name:_____ Relation:_____

Insured's DOB:__/__/__ Insured's SS#:_____

Insured's Employer:_____

Insured's Employer's Address:_____

City_____State_____Zip_____

Orthodontic Coverage? [ ] Yes [ ] No

Secondary

Insurance Co. Name:_____

Insurance Address:_____

City:_____State_____Zip_____

Insurance Phone:(____)_____

Group#(Plan, Local, or Policy#):_____

Insured's Name:_____ Relation:_____

Insured's DOB:__/__/__ Insured's SS#:_____

Insured's Employer:_____

Insured's Employer's Address:_____

City_____State_____Zip_____

Authorization

This office reserves the right to verify the credit status of potential patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. If Dr. Schechtman's office accepts the insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payments and deductibles that my insurance does not cover.

I hereby authorize Dr. Schechtman to release all information necessary to secure the payment of benefits.

I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature _____Date_____

Medical History

Do you have a Personal Physician? Y N
Physician's Name_____
Phone #:_____Date of last visit_____

Your current physical health is: [] Good [] Fair [] Poor

Are you currently under the care of a physician? Y N
Please explain:_____
Do you smoke or use tobacco in any form ? Y N
Have you had any metal rods, pins or implants? Y N
Are you taking any prescription / over the counter drugs? Y N
Please List:_____
Have you ever taken Phen-fen? Y N
If so, When?_____
For Women: Are you taking birth control pills? Y N
Are you pregnant? Weeks #:_____ Y N
Are you nursing? Y N

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

Y	N	Abnormal Bleeding	Y	N	Hepatitis
Y	N	AIDS	Y	N	Herpes/Fever Blisters
Y	N	Alcohol/Drug Abuse	Y	N	High Blood Pressure
Y	N	Anemia	Y	N	HIV
Y	N	Arthritis	Y	N	Hospitalized for Any Reason
Y	N	Artificial Bones/Joints	Y	N	Kidney Problems
Y	N	Artificial Valves	Y	N	Liver Disease
Y	N	Asthma	Y	N	Low Blood Pressure
Y	N	Blood Transfusion	Y	N	Mitral Valve Prolapse
Y	N	Cancer/Chemotherapy	Y	N	Pacemaker
Y	N	Colitis	Y	N	Psychiatric Problems
Y	N	Congenital Heart Defect	Y	N	Radiation Treatment
Y	N	Diabetes	Y	N	Rheumatic/Scarlet Fever
Y	N	Difficulty Breathing	Y	N	Seizures
Y	N	Emphysema	Y	N	Shingles
Y	N	Epilepsy	Y	N	Sickle Cell Disease/Traits
Y	N	Fainting Spells	Y	N	Sinus Problems
Y	N	Frequent Headaches	Y	N	Stroke
Y	N	Glaucoma	Y	N	Thyroid Problems
Y	N	Hay fever	Y	N	Tuberculosis (TB)
Y	N	Heart Attack/Surgery	Y	N	Ulcers
Y	N	Heart Murmur	Y	N	Venereal Disease
Y	N	Hemophilia			

Please list any serious medical condition(s) that you have ever had:

_____
_____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Latex
Y	N	Codeine	Y	N	Penicillin
Y	N	Dental Anesthetics	Y	N	Tetracycline
Y	N	Erythromycin	Y	N	Other
Y	N	Jewelry / Metal			

Please list any other drugs / materials that you are allergic to:

Dental History

What are the main concerns that you would like orthodontics to accomplish:

_____
_____

Have you ever had or been evaluated for Orthodontic treatment? Y N
Have you ever had a serious/difficult problem associated with any previous dental work? Y N
Do you now or have you ever experienced pain / discomfort in your jaw joint (TMD/TMJ) Y N
Your current dental health is:
[] Good [] Fair [] Poor
Do you still have wisdom teeth? Y N
Have you ever had an injury to your: Y N
Mouth Teeth Chin
Do you have any speech problems? Y N
_____
Do you generally breathe through your mouth? Y N
While Awake? Y N
While Asleep? Y N
Do you have any missing or extra permanent teeth? Y N

Are you happy with the way your smile looks? Y N

If not, what would you change?_____
_____

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 that 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. This office reserves the right to verify the credit status of potential patients and/ or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

Signature_____Date_____

OFFICE USE ONLY - OFFICE USE ONLY

I verbally reviewed the medical / dental information with the patient named herein.

Initials:_____ Date:_____
Doctor's Comments:_____
_____
_____
_____