VINCENT TEAM orthodontics

1030 E 11400 S Ste B Sandy, Utah 84094
Phone 801.495.2560
VincentTeamOrtho.com

PATIENT INFORMATION

Date_____

Patients Name _____
Last First Middle

Address_____
Street City State Zip

Home Phone _____ Birth Date _____Social Security #_____

If patient is a minor, give parent or guardian's name _____

Patient: _____Responsible Party: _____
E-mail Address E-mail Address

RESPONSIBLE PARTY INFORMATION

Name _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____Home Phone _____ Work Phone _____

Previous Address (if less than 3 years) _____
Street City State Zip

Social Security # _____Birth Date _____ Relationship to Patient _____
Employer _____Occupation _____ # Years Employed _____
Spouse's Name _____ Relationship to Patient _____
Last First Middle
Spouse's Employer _____ Occupation _____ # Years Employed _____
Spouse's Social Security # _____Spouse's Birth Date _____

INSURANCE INFORMATION

Insured Name _____DOB _____ Social Security # _____
Insurance Company _____ Group # _____ Local # _____
Insurance Co. Address _____
Do you have dual coverage? Yes ? No ? If yes, please continue _____
Insured Name _____ DOB _____ Social Security # _____
Insurance Company _____ Group # _____ Local # _____
Insurance Co. Address _____ Insured Employer_____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____
Complete Address _____
Phone _____ Relationship to Patient _____

CREDIT REPORT AUTHORIZATION

I understand that a credit bureau report may be obtained if an orthodontic financial plan is requested.

Signature _____ Date _____

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PATIENT MEDICAL HISTORY

Patient's Name _____School Name_____

Name and ages of children and siblings_____

_____

PREVIOUS CONDITIONS

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

☐ Anemia	☐ Excessive	☐ Bleeding	☐ Pain in Jaw Joints
☐ Asthma	☐ Heart Problems	☐ Rheumatic Fever	☐ Cold Sores or Fever Blisters
☐ Hepatitis	☐ Sinus Problems	☐ Diabetes	☐ HIV Positive (AIDS)
☐ Tonsillitis	☐ Drug Addiction	☐ Nervous Disorders	☐ Tuberculosis
☐ Endocrine Problems			

Does the patient gag easily? ☐ Yes ☐ No

Does the patient wear contact lenses? ☐ Yes ☐ No

Does the patient have frequent ear infections? ☐ Yes ☐ No

Have tonsils and/or adenoids been removed? ☐ Yes ☐ No At what age? _____

Women: Are you pregnant? ☐ Yes ☐ No

Are medications now being taken? ☐ Yes ☐ No Please list type and reason:_____

Does the patient have any allergies to: ☐ Yes ☐ No If yes, please list: _____

foods, medications, environmental (i.e. hay fever) _____

PATIENT DENTAL HISTORY

Dentist's Name _____ Approximate date of last dental exam _____

Have there ever been any injuries to the face, mouth, or teeth? ☐ Yes ☐ No If yes, please explain:_____

Has the patient ever sucked their fingers or thumb? ☐ Yes ☐ No Until what age? _____

Does patient have any speech problems? ☐ Yes ☐ No

Is patient a mouth breather while asleep? ☐ Yes ☐ No

Is patient a mouth breather while awake? ☐ Yes ☐ No

Have you been informed on any extra/missing permanent teeth? ☐ Yes ☐ No

Has patient ever had a previous orthodontic exam? ☐ Yes ☐ No

Have any family members had orthodontic treatment? ☐ Yes ☐ No

Is there pain in the jaw joint? If Yes... ☐ Right ☐ Left When did this begin? _____

Is there any popping or cracking of the jaw joint? If Yes... ☐ Right ☐ Left When did this begin? _____

Does patient clench or grind teeth? If Yes... ☐ Night ☐ Day When did this begin? _____

Does patient have headaches? ☐ Yes ☐ No

Frequency: _____ Location: _____

What is the chief concern that brought you to our office? _____

_____

_____