RESET THIS FORM

RACHEL E REICHARD DDS MS
orthodontics

PATIENT INFORMATION

Last Name: _____First: _____Middle: _____

Salutation: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other:_____

Nickname:_____ Date of Birth: _____ Sex: ☐ Male ☐ Female

Home Address: _____

City: _____ State: Zip Code:_____

Home Phone: _____ Cell Phone: _____

Preferred E-mail Address:_____

Employer:_____

Employer's Address:_____

Occupation: _____Work Phone:_____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

GENERAL INFORMATION

Whom may we thank for referring you? _____

General Dentist: _____Date of last visit: _____

SPOUSE INFORMATION	ORTHODONTIC INSURANCE INFORMATION (if applicable)
Name: _____ Title Address: _____ City: _____State: Home Phone: _____ Cell Phone: _____ Employer: _____ Work Phone: _____ Preferred E-mail: _____	Insurance Co Name:_____ Insurance Co Address:_____ Insurance Co Phone: _____ Group Number: _____ Insured's Name:_____ Relationship to patient: _____ Insured's Date of Birth:_____ Insured's SSN/Insurance ID#: _____

Name of person responsible for account: _____

Billing Address: _____City:_____State:

Home Phone: _____Work Phone: _____Cell Phone:_____

Employer: _____

DENTAL HISTORY

What are the main concerns that you would like to address with orthodontic treatment?

_____

Have you been evaluated for orthodontic treatment before? □ Yes □ No

Have you ever had any problems/complications associated with any previous dental work? □ Yes □ No

Have you ever had clicking, popping, pain or tenderness in your jaw joints (TMJ/TMD)? □ Yes □ No

If yes, please describe:_____

Has your jaw ever "locked" open or closed? □ Yes □ No

Do you clench/grind your teeth □ Yes □ No

How would you rate your current oral health? □ Good □ Fair □ Poor

Do you feel your gums are healthy? □ Yes □ No

Do you brush your teeth daily? □ Yes □ No

Do you floss your teeth daily? □ Yes □ No

Have you had an injury to your mouth, teeth or chin? □ Yes □ No

Do you like your smile? □ Yes □ No

MEDICAL HISTORY

Are you currently under the care of a physician? □ Yes □ No

Describe your current physical health: □ Good □ Fair □ Poor

Physician Name: _____Phone: _____

Address: _____

Please list all medications that you are currently taking: _____

Please list all drugs that you are allergic to: _____

Have you ever had any of the following medical problems?

Allergy to Latex/Metals	□ Yes □ No	Heart Murmur	□ Yes □ No	Difficulty Breathing	□ Yes □ No	Kidney/Liver Problems	□ Yes □ No
Handicaps/ Limitations	□ Yes □ No	Congenital Heart Defect	□ Yes □ No	Tuberculosis	□ Yes □ No	Hepatitis	□ Yes □ No
Hearing Impairments	□ Yes □ No	Mitral Valve Prolapse	□ Yes □ No	Asthma	□ Yes □ No	Hemophilia/Abnormal Bleeding	□ Yes □ No
Fever Blisters	□ Yes □ No	Artificial Valves	□ Yes □ No	Emphysema	□ Yes □ No	Blood Transfusion	□ Yes □ No
Sinus Problems	□ Yes □ No	Heart Attack/Stroke	□ Yes □ No	Cancer	□ Yes □ No	Anemia/Blood Disorders	□ Yes □ No
Severe/Frequent Headaches	□ Yes □ No	High/Low Blood Pressure	□ Yes □ No	Chemotherapy/ Radiation	□ Yes □ No	Diabetes	□ Yes □ No
Psychiatric Problems	□ Yes □ No	Heart Surgery/Pacemaker	□ Yes □ No	Epilepsy/ Convulsions	□ Yes □ No	HIV+/AIDS	□ Yes □ No
Drug/Alcohol Abuse	□ Yes □ No	Arthritis	□ Yes □ No	Ulcers/Colitis	□ Yes □ No	Hospital Stays	□ Yes □ No
Rheumatic Fever	□ Yes □ No	Artificial Bones/Joints	□ Yes □ No	Venereal Disease	□ Yes □ No	Any Operations	□ Yes □ No

If yes, please describe:

For the signatures below, you can print and physically sign. Or, you can electronically sign by typing your name into the signature fields.

I acknowledge that I have received this office's Privacy Practice Notice.

Signature: _____Date: _____

I understand that this information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____Date: _____