B R A C E   P L A C E

O R T H O D O N T I C S

Patient Information

Patient's Name: ____
First Middle Last

Date of Birth: ____/____/____ Age: ________ ☐ Male ☐ Female Phone#:(____)_____-_______

Address: ____
Street Town State Zip

If Patient is a Minor Parents'/guardians' name(s): ____

Parents/Guardians' marital status ☐ Married ☐ Divorced ☐ Single * Custodial Parent: ☐ Mother ☐ Father ☐ Joint

Names and ages of brothers and sisters: ____

Responsible Party Information

Name: ____ Relationship to patient: __________
First Middle Last

Address: ____
Street Town State Zip

Home Phone: (____) _____-_________ Work Phone:(____) _____-_________ Cell Phone: (____) _____-_________

Social Security #: ______-______-______ Date of Birth : ______/______/______

Employer: ______________________ Occupation: ______________________

Spouse's Name: ____ Relationship to patient: __________
First Middle Last

Employer: ______________________ Occupation: ______________________

Home Phone: (____) _____-_________ Work Phone:(____) _____-_________ Cell Phone: (____) _____-_________

Social Security #: ______-______-______ Date of Birth : ______/______/______

Dental Insurance Information

Primary	Secondary
Policy Holder: ______________	Policy Holder: ______________
SS# of Holder: ______________	SS# of Holder: ______________
Date of Birth of Policy Holder: ______/______/______	Date of Birth of Policy Holder: ______/______/______
Employer: ______________	Employer: ______________
Insurance Company: ______________	Insurance Company: ______________
Insurance Address: ______________	Insurance Address: ______________
Group/Policy #: ______________	Group/Policy #: ______________

- I hereby authorize release of any information to other health care providers, insurance companies, and business associates including sonal health information as well as administrative data which is not strictly dental or medical in nature. I additionally authorize payı directly to Brace Place of the insurance benefits otherwise payable to me.
- I am giving my consent to you to use and disclosure of my protected health information to carry out treatment, payment activities health care operations.
- I certify that the above information is complete and true to the best of my knowledge.

Patient's Dental/Medical History

What are your primary concerns for today's visit?: ______________________________

____

Dentist Name: ______________________________

Address: ______________________________

Phone#: (____)____-__________ Last Visit: __________

Physician: ______________________________

Address: ______________________________

Phone #: (____)____-__________ Last Visit: __________

Please circle yes or no:

Yes No Patient is currently under the care of a physician

If so, why: ______________________________

____

____

Yes No Patient is currently taking or has taken in the past bisphosphonates?

Yes No Patient is currently or in the past has been treated for cancer, tumors or received radiation treatment and/or chemotherapy?

Yes No Is patient currently taken any prescribed medication?

Medication: ________________ Taken for: ____________

Medication: ________________ Taken for: ____________

Medication: ________________ Taken for: ____________

Yes No Are tonsils and adenoids present? ____________

Yes No Had an unusual reaction to any drug? Please list:

____

____

Now or in the past, have you had: (circle yes or no)

YES NO Heart Murmur, or Rheumatic Fever
YES NO Mitral Valve Prolapse
YES NO Pre Medication is required before dental procedures
YES NO Anemia or Bleeding Disorders
YES NO Tuberculosis or Hepatitis
YES NO Diabetes
YES NO Epilepsy, Convulsions, Seizures, Fainting Spells
YES NO Problems of the Immune System
YES NO Asthma, Breathing Problems, Snoring
YES NO Sinus problems, Frequent Colds, Cold Sores
YES NO Do You Smoke or Chew Tobacco
YES NO Stomach Ulcers
YES NO Thyroid or Hormonal Imbalance
YES NO Rheumatoid or arthritic conditions
YES NO ADD/ADHD
YES NO Nervous Disorder
YES NO Thumb/Finger Sucking Habit
YES NO Lip / Nail Biting
YES NO Abnormal Swallowing Habit (Tongue Thrusting)
YES NO Injury to Jaws or Teeth or Concussion
YES NO Severe Headaches or Facial Pain
YES NO Difficulty in Chewing or Jaw Opening/Closing

YES NO Vision or Hearing Problems
YES NO Latex Allergies (gloves, balloons, band aids)
YES NO Metals Allergies (jewelry, clothing snaps)
YES NO Seasonal Allergies
YES NO Other Allergies Please List: ______________

____

____

If Patient is a Minor:

YES NO Is Child Adopted?
YES NO Is Child Aware of Adoption?

If Minor Female:

YES NO Has started Mensuration

Date of First Period: mo.____/yr.____

If Minor Male:

YES NO Has Voice Changed? mo.____/yr.____

YES NO Started Shaving? mo.____/yr.____

Is there any other information we should know about the pati
health?: ______________________________

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Please check all the sources that influenced you to choose Brace Pl

- ☐ Doctor ______________________referred me
- ☐ My dentist's hygienist, assistant or staff member referred me
- ☐ I selected you from my insurance list of participating doctors
- ☐ ______________, my relative/friend referred me.
- ☐ I saw you in the Yellow Pages.
- ☐ I saw your advertisement in (name source)__________
- ☐ I visited your website.
- ☐ Other (please specify): ______________

OFFICE COMMENTS: ______________________________

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