FLAGSHIP
Orthodontics

Welcome to Flagship Orthodontics. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible.

ADULT PATIENT INFORMATION

Date_____

Patient's name_____Male/Female_____
Last First Middle

Residence_____
Street City State Zip

Mailing Address _____
Street City State Zip

Home phone_____ Work phone_____

Cell Phone #_____ Carrier (e.g. Verizon/AT&T)_____

Birthdate_____

Email Address_____ Marital Status: Single__ Married__

Employer_____Occupation_____No. years employed _____

How did you hear about our practice? _____

DENTAL INSURANCE INFORMATION

Insurance Company_____ Ins. Phone Number_____

Group No._____ Policy No._____

Employer_____ Work Phone No._____

Policy Holder's Name_____Relation_____

Policy Holder's Social Security #_____Policy Holder's DOB_____

Insurance Company Phone No._____

Do you have dual coverage? Yes_____ No_____ If yes:

Insurance Company_____ Ins. Phone Number_____

Group No._____ Policy No._____

Employer_____ Work Phone No._____

Policy Holder's Name_____Relation_____

Policy Holder's Social Security #_____Policy Holder's DOB_____

Insurance Company Phone No._____

EMERGENCY INFORMATION

Emergency contact name_____

Relation _____

Address _____

Phone _____

MEDICAL HISTORY

Physician_____ Date of Last Visit_____
Address_____ Phone _____
Please circle Yes or No (If Yes, please fill in details – additional space provided below)

Yes No Are you currently being treated by a physician?
Reason: _____
_____
Yes No Are you taking any medications including over-the-counter (please list)? _____
_____
Yes No Are you allergic to any medications? _____
Yes No Do you have a history of a major illness? _____
_____
Yes No Have you had any operations? _____
_____
Yes No Have you ever been involved in a serious accident? _____
_____
Yes No Are you or have you been a regular tobacco user?_____
Yes No Have you seen a physician in the last 12 months? Why? _____
_____

Female Patients only:

Yes No Are you pregnant?_____
Yes No Has menstruation started? _____

_____
_____
_____
_____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of?

_____
_____
_____
_____

DENTAL HISTORY

General Dentist _____ Date of last visit _____
What concerns you most about your teeth? _____
_____
_____

Yes No Are you presently in any dental pain? _____
_____
Yes No Have your wisdom teeth been removed? _____
Yes No Have you ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth, or teeth?_____
_____
Yes No Do your gums bleed when brushing? _____
Yes No Are you a mouth breather? _____
Yes No Have you previously visited an orthodontist? If so, how recently?
_____
Yes No Have you ever experienced any jaw joint pain/discomfort (TMJ/TMD)?
Yes No Do you experience any jaw clicking or popping?_____
Yes No Do you grind or clench your teeth?_____
Yes No Have your tonsils or adenoids been removed?_____
Yes No Do you have any speech problems?_____
Yes No Do you have (or have you previously had) any of the following habits: lip sucking/biting, nail biting, chewing/eating problem?_____
_____

BENEFITS

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

I hereby authorize the release of any information pertaining to my orthodontic treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payment of any benefits to the office. I understand that I am responsible for any amount not covered by insurance.

Signature: _____ Date: _____