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.

CHILD/ADOLESCENT 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_____

Birthdate_____

How did you hear about our practice? _____

PARENT/LEGAL GUARDIAN INFORMATION

FATHER

Name_____
Last First Middle

Address (if different from patient) _____
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 _____

MOTHER

Name_____
Last First Middle

Address (if different from patient) _____
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 _____

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 Is the patient currently being treated by a physician?
Reason: _____
_____

Yes No Is the patient currently taking any medications including over-the-counter (please list)?

_____

Yes No Is the patient allergic to any medications? _____
Yes No Does the patient have a history of a major illness?_____
_____

Yes No Has the patient had any operations?_____
_____

Yes No Has the patient ever been involved in a serious accident? _____
_____

_____
_____
_____
_____

Circle any of the medical conditions below that the patient has or has had previously.

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 or your child most about your child's teeth? _____
_____
_____

Yes No Is the patient presently in any dental pain? _____
_____
Yes No Has the patient's wisdom teeth been removed? _____
Yes No Has the patient ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth, or teeth? _____
_____
Yes No Do gums bleed when brushing? _____
Yes No Is the patient a mouth breather? _____
Yes No Has the patient previously visited an orthodontist? If so, how recently?
_____
Yes No Has the patient ever experienced any jaw joint pain/discomfort (TMJ/TMD)?
Yes No Experience jaw clicking or popping? _____
Yes No Does the patient grind their teeth (this generally occurs while sleeping)? _____
Yes No Have the tonsils or adenoids been removed? _____
Yes No Are there speech problems? _____
Yes No Does the patient have (or has the patient 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 child's 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: _____