STEVENS
SPECTACULAR SMILES FOR ALL AGES
ORTHODONTICS

Lucas E. Stevens, D.M.D., M.S., P.A.

ORTHODONTIC PATIENT INFORMATION

Patient's Number:_____ Age:_____ Birthday:_____ Sex:_____

Patient's Name:_____

Home Address: _____
STREET CITY STATE ZIP CODE

Home Ph:_____ Work Ph:_____ Ext._____ Cell:_____ SSN:_____

Person Responsible for Account:

Name:_____ Relationship: _____

Home Address: _____
STREET CITY STATE ZIP CODE

Home Phone:_____ Work Phone:_____ Ext._____ SSN:_____

How Long at this address?_____ Date of Birth:_____

Previous Address (if less than 3 years): _____

Employer:_____ Occupation:_____ Years Employed:_____

Spouse's Name: _____

Employer:_____ Occupation:_____ Years Employed:_____

SSN:_____ Birthdate:_____ Work Phone:_____ Ext._____

Patient lives with: _____

Other Family Members that have been seen by us:_____

Name and ages of brothers and sisters (if child): _____

Name and ages of children (if adult): _____

Dental Insurance Information:

Insured's Name:_____ SSN: _____

Home Address:_____ Work Ph:_____ Ext._____ Home Ph: _____

Insurance Company:_____ Employer:_____ Group #: _____

Insurance Company Address:_____

Do you have dual coverage?: ☐ Yes ☐ No If yes, complete the following:

Insured's Name:_____ SSN: _____

Home Address:_____ Work Ph:_____ Ext._____ Home Ph: _____

Insurance Company:_____ Employer:_____ Group #: _____

Insurance Company Address:_____

Other Information:

Dentist:_____ Physician:_____

School:_____ Grade: _____

Have you ever been evaluated for Orthodontic Treatment? _____

(Please complete the reverse side of this form)

Patient's Medical History

Have you been under the care of a physician in the past two years:_____

Have you ever had or do you now have any of the following:

- ☐ Prolonged bleeding
- ☐ Epilepsy
- ☐ Diabetes
- ☐ Heart Problems
- ☐ Rheumatic fever
- ☐ Bone disorders
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ AIDS or HIV
- ☐ Cancer
- ☐ Anemia
- ☐ Asthma
- ☐ Fainting or dizziness
- ☐ Nervous disorder
- ☐ Endocrine problems
- ☐ Liver problems
- ☐ Birth defects
- ☐ Allergies

Have you had any surgery? ☐ Yes ☐ No

Have you been hospitalized? ☐ Yes ☐ No

List any medications you are now taking_____

_____

_____

Have you ever been told you need to take antibiotics before a dental procedure? ☐ Yes ☐ No

Patient's Dental History

Please check any of the following that apply:

- ☐ Any family members who have had orthodontics
- ☐ Teeth sensitive to hot or cold
- ☐ Injuries to your face, jaw, mouth or teeth
- ☐ Bleeding gums, bad taste in mouth
- ☐ Root canals, crowns or bridges
- ☐ Suck your thumb and/or fingers
- ☐ Any clicking, popping or pain of the jaw or jaw joint (TMJ)
- ☐ Any missing teeth or extra teeth
- ☐ Trouble chewing

Date of most recent dental exam_____

How often do you brush your teeth_____

How often do you floss your teeth_____

What is the main thing you would like to find out by coming to see Dr. Stevens and what would you like to see done for your smile?_____

_____

_____

Who may we thank for referring you to our office?_____

I have read and understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to the medical/dental status, I will so inform this office. I understand that, in order to extend favorable financing to me, credit bureau reports may be obtained where appropriate.

Signature (Parent's signature if minor)_____Date_____