MOUNTAIN VIEW ORTHODONTICS
F. RICHARD BECKWITH DDS MS PC
Specialist in Orthodontics

ADULT

NAME_____ Prefer to be called_____ Sex___ Birth date ____/____/____ Age_____

Address_____ City_____ Zip_____ Cell Phone____-____-_____

Work phone ____-____-_____ Hm. phone____-____-_____ E-mail (to confirm appts)_____

Employer_____ Occupation_____ Where/when are best times to reach you? _____

Your hobbies/interests?_____

Are there other family members seen or who need to be seen by us? _____

Has anyone in the family had braces? Y / N Who?_____ Were you/they pleased with the results? Y / N

Whom may we thank for referring you?_____ General Dentist _____

How often do you see the dentist?_____ Date of last dental exam (MM/YY)_____/_____

What are the main concerns that you would like orthodontics to address? _____

Have you had or been evaluated for orthodontic treatment? When?____/____Where?_____	Y	N
Are you willing to wear orthodontic appliances (braces) if they are recommended?	Y	N
Are you self-conscious of your teeth?	Y	N
Have there been any injuries to your face, mouth, teeth, or chin?	Y	N
Do you have or have you had pain/discomfort in your jaw joint (TMJ)?	Y	N
Do you have any dental problems at this time (pain, cavities, etc.)?	Y	N
Do you snore when sleeping? If so, please circle one. Constantly / Frequently / Occasionally	Y	N
Please circle if: adenoids / tonsils / both have been removed. When? _____/_____	Y	N
Are you apprehensive about receiving dental care?	Y	N

Please explain any 'Y' answers above_____

Women: Are you pregnant? Y or N Do you anticipate becoming pregnant?	Y	N

Do you have or have you had any of the following **habits or problems**?

Thumb/finger sucking	Y	N	Speech problems	Y	N
Mouth breathing	Y	N	Smoke or chew tobacco	Y	N
Clenching/grinding teeth	Y	N	Substance abuse problems	Y	N

Please explain any 'Y' answers above_____

Are You **allergic** to any of the following?

Penicillin	Y	N	Nickel or other metal	Y	N
Latex, vinyl, or acrylic	Y	N	Other allergies_____		

If any of your answers are 'Y', what happens when you are exposed to the allergen?_____

MEDICAL INFORMATION

Did/do you have?:

Ever been hospitalized	Y	N	Heart condition or heart problems	Y	N
Recurrent or chronic illness	Y	N	Hepatitis or liver problems	Y	N
Asthma or respiratory problems	Y	N	Thyroid or other hormone therapy	Y	N
Blood transfusion/AIDS/HIV virus	Y	N	Osteoporosis	Y	N
Bone fractures or major accident	Y	N	Psychiatric counseling	Y	N
Cancer, radiation, or chemotherapy	Y	N	Sensory or Anxiety concerns	Y	N
Diabetes	Y	N	Frequent or severe headaches	Y	N
Epilepsy or seizures	Y	N	Lip or inside mouth lesions (sores)	Y	N

Please explain any 'Y' answers or list any health concerns not addressed above:_____

_____

Some medications can affect tooth movement. Please list all medications that you are taking and the condition for which the medication was prescribed: NONE /_____

_____ **Your Physician(s):**_____

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PERSON RESPONSIBLE FOR ACCOUNT_____

Billing Address_____ City_____ State_____ Zip_____

Phone Numbers: Cell_____ Home _____ Work _____

Relationship to patient_____ Employer_____

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

_____

Signature Date

☐ Mark if no orthodontic insurance

IF THERE IS ORTHODONTIC INSURANCE AND YOU WISH TO HAVE OUR OFFICE SUBMIT YOUR INSURANCE, PLEASE COMPLETELY FILL OUT THE FOLLOWING INSURANCE SECTION AND SIGN BELOW:

PRIMARY ORTHODONTIC INSURANCE:

Insurance Co. Name_____

Insurance Co. Address_____

Insurance Co.Phone #_____Group #_____ Member ID or Soc Sec #_____

Insured's Name_____ Relation to patient_____

Insured's employer_____ Insured's birthdate_____

SECONDARY ORTHODONTIC INSURANCE:

Insurance Co. Name_____

Insurance Co. Address_____

Insurance Co.Phone #_____ Group #_____ Member ID or Soc Sec #_____

Insured's Name_____ Relation to patient _____

Insured's employer_____Insured's birthdate_____

I authorize the release of information relating to orthodontic claims. I understand that I am responsible for all costs of treatment.

X

_____ _____

Signed (Patient) Date

I authorize payment directly to Mountain View Orthodontics of the insurance benefits otherwise payable to me.

X

_____ _____

Signed (insured person) Date