MOUNTAIN VIEW ORTHODONTICS
F. RICHARD BECKWITH D.D.S. M.S. P.C.
*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 or Invisalign) 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 |
| Are you apprehensive about receiving dental care? | Y | N |
| Do you snore when sleeping? If so, please circle one. Nightly / Frequently / Occasionally | Y | N |

Please explain any 'Y' answers above_____

| | | |
|---|---|---|
| **Please circle** if: adenoids / tonsils / both have been removed. When? _____/_____ | Y | N |
| **Women:** Are you pregnant? Y N Do you anticipate becoming pregnant? | Y | N |

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

| | | | | | |
|---|---|---|---|---|---|
| Breathe through mouth when awake | Y | N | Thumb/finger sucking | Y | N |
| Sleep with your lips apart | Y | N | Speech problems | Y | N |
| Clenching/grinding teeth - awake | Y | N | Smoke or chew tobacco | Y | N |
| Clenching/grinding teeth - sleeping | 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