LVL ORTHODONTICS

Patient Name _____ Birth Date _____
(Last) (First) (Middle)

Today's Date _____ Sex _____ Age _____ E-mail _____

Address _____ Cell Phone _____
(Street) (City) (State) (Zip)

In case of an Emergency contact _____ Relationship _____ Phone Number _____

Employed By _____ Occupation _____

RESPONSIBLE PARTY ☐ Check if Self

IF YOU ARE A MINOR → Parents are: Married Widowed Divorced Separated Patient Lives With?

MOTHER'S NAME	FATHER'S NAME
Social Security # DOB	Social Security # DOB
Best Phone Number	Best Phone Number
Employed By	Employed By
Occupation	Occupation

PLEASE DESCRIBE YOUR MAIN CONCERN _____

HOW WERE YOU REFERRED?

☐ Dentist ☐ Family ☐ Friends
☐ Drive-By ☐ Website ☐ Invisalign
☐ Other

Referral's Full Name:
_____

☐ Yes ☐ No – Has this patient ever been seen for any other orthodontic consultation?

If yes, who was the orthodontist? _____ Date _____

☐ Yes ☐ No – Has this patient ever had previous orthodontic treatment?

Who was the orthodontist? _____ City _____

☐ Yes ☐ No – Has anyone in your family had orthodontic treatment in our office?

DENTAL INSURANCE

PRIMARY INSURED INFORMATION

Name of Insured _____

Insured's DOB _____ Insured's SSN or ID _____

Relationship to Patient _____

Address of Insured _____

City _____ State _____ Zip _____

Employed by _____

Dental Ins. Co. Name _____

Ins Address _____

City _____ State _____ Zip _____

Ins Group # _____ Ins Phone _____

SECONDARY INSURED INFORMATION

Name of Insured _____

Insured's DOB _____ Insured's SSN or ID _____

Relationship to Patient _____

Address of Insured _____

City _____ State _____ Zip _____

Employed by _____

Dental Ins. Co. Name _____ Ins

Address _____

City _____ State _____ Zip _____

Ins Group # _____ Ins Phone _____

PATIENT MEDICAL HISTORY

Physician_____ Office Phone _____ Date of Last Exam_____

Please check Yes or No (If yes, please fill in details)	YES	NO
1. Are you taking any medication? _____	☐	☐
2. Are you allergic to any medication? Latex or Nickel? _____	☐	☐
3. Do you have a history of a major illness? _____	☐	☐
4. Have you had any major operations? _____	☐	☐
5. Have you ever been involved in a serious accident? _____	☐	☐
Female Patients only:		
6. Are you pregnant? _____	☐	☐
7. Has menstruation started? _____	☐	☐

8. Do you have, or have you had any of the following?

	YES	NO		YES	NO		YES	NO
Abnormal Bleeding	☐	☐	Drug/Alcohol Problems	☐	☐	Nervous Disorders	☐	☐
ADD/Autism	☐	☐	Epilepsy	☐	☐	Pneumonia	☐	☐
Anemia	☐	☐	Gastrointestinal disorders	☐	☐	Prolonged Bleeding	☐	☐
Arthritis	☐	☐	Heart Murmur	☐	☐	Radiation/Chemotherapy	☐	☐
Asthma/Hay fever	☐	☐	Heart Problems	☐	☐	Rheumatic Fever	☐	☐
Bone Disorders	☐	☐	Hepatitis/Liver Problems	☐	☐	Severe/Frequent Headaches	☐	☐
Cerebral Palsy	☐	☐	Herpes	☐	☐	Sinus Problems	☐	☐
Congenital Heart Defects	☐	☐	High Blood Pressure	☐	☐	STD's	☐	☐
Diabetes	☐	☐	HIV-AIDS	☐	☐	Tuberculosis	☐	☐
Dizziness	☐	☐	Kidney Problems	☐	☐	Tumor or Cancer	☐	☐

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

PATIENT DENTAL HISTORY

Dentist and Location _____ Date of Last Exam_____

Please check Yes or No (If Yes, please fill in details)	YES	NO	
1. Do you clench or grind your teeth?	☐	☐	_____
2. Do you have TMJ pain?	☐	☐	_____
3. Have you ever lost or chipped any teeth?	☐	☐	_____
4. Have there been any injuries to your face, mouth or teeth?	☐	☐	_____
5. Is any part of your mouth sensitive to temperature or pressure?	☐	☐	_____
6. Have you had your tonsils/adenoids removed?	☐	☐	_____
7. Have you ever experienced any unfavorable reaction to dentistry?	☐	☐	_____

AUTHORIZATION TO OBTAIN INFORMATION

I authorize any dentist, physician, medical practitioner, hospital, clinic, any dental or medically related facility to release any information available to help us with diagnosis and prognosis of my or my child's case. Information obtained by use of this authorization will not be released to LVL Orthodontics without my express permission. I understand where appropriate, credit bureau reports may be obtained.

Signature of Patient or Legal Guardian _____ Date_____

TO THE BEST OF MY KNOWLEDGE, ALL OF THE ANSWERS ON THE FRONT & BACK SIDE OF THIS FORM ARE TRUE AND CORRECT. IF EVER THERE IS A CHANGE IN HEALTH, OR ANY MEDICATION CHANGE, I WILL INFORM THE OFFICE.

Signature of Patient or Legal Guardian _____ Date_____