# WELCOME TO DJM ORTHODONTICS!

DAVID J MYERS, DDS, MS

Please fill out this form completely. The better we communicate, the better we can care for you!

## 1 ABOUT YOU

Today's Date: _____

E-Mail Address: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: ___/___/___ Age: _____ SS #: _____

Home Address: _____
APT/CONDO#

_____
CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm # ( ) _____ Cell/Other #: _____

Wk#: ( ) _____ Ext: _____ DL#: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

General Dentist: _____

Last Visit Date: _____

## 2 SPOUSE INFORMATION

His/Her Name: _____

Employer: _____

Wk#: ( ) _____ Ext. _____ SS#: _____

Birthdate: ___/___/_____

**PERSON RESPONSIBLE FOR ACCOUNT:** _____

Wk#: ( ) _____ Ext: _____ Hm#: ( ) _____

Billing Address: _____

Relation: _____ SS#: _____

Employer: _____ DL#: _____

## 3 ORTHODONTIC INSURANCE

### PRIMARY

Orthodontic Coverage: ☐ Yes ☐ No Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: ( ) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID#: _____

Insured's Employer: _____

### SECONDARY

Orthodontic Coverage: ☐ Yes ☐ No Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: ( ) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID#: _____

Insured's Employer: _____

**IN THE EVENT OF AN EMERGENCY, IS THERE SOMEONE WHO LIVES NEAR YOU THAT WE SHOULD CONTACT?**

His/Her Name: _____ Relation: _____

Wk#: ( ) _____ Hm#: ( ) _____

## 4 MEDICAL HISTORY

**DO YOU HAVE A PERSONAL PHYSICIAN?** ☐ YES ☐ NO

Physician's Name: _____

Phone#: ( ) _____ Date of last visit: _____

CONTINUED ON BACK

## 4½ MEDICAL HISTORY *CONTINUED*

***YOUR CURRENT PHYSICAL HEALTH IS:*** ☐ *GOOD* ☐ *FAIR* ☐ *POOR*

Are you currently under the care of a physician? ☐ Yes ☐ No

Please Explain: _____

Are you taking any prescription/over-the-counter drugs? ☐ Yes ☐ No

Please list each one: _____

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week#: _____

Are you nursing? ☐ Yes ☐ No

***HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?***

| | | | |
|---|---|---|---|
| Y N | Abnormal Bleeding | Y N | Hemophilia |
| Y N | Anemia | Y N | Hepatitis |
| Y N | Artificial Bones/Joints/Valves | Y N | High/Low Blood Pressure |
| Y N | Asthma/Arthritis | Y N | HIV+/AIDS |
| Y N | Blood Transfusion | Y N | Hospitalized for Any Reason |
| Y N | Cancer/Chemotherapy | Y N | Kidney Problems |
| Y N | Congenital Heart Defect | Y N | Mitral Valve Prolapse |
| Y N | Diabetes | Y N | Psychiatric Problems |
| Y N | Difficulty Breathing | Y N | Radiation Treatment |
| Y N | Drug/Alcohol Abuse | Y N | Rheumatic/Scarlet Fever |
| Y N | Emphysema | Y N | Sever/Frequent Headaches |
| Y N | Epilepsy/Seizures/Fainting | Y N | Shingles |
| Y N | Fever Blisters/Herpes | Y N | Sickle Cell Disease/Traits |
| Y N | Glaucoma | Y N | Sinus Problems |
| Y N | Heart Attack/Stroke | Y N | Tuberculosis (TB) |
| Y N | Heart Murmur | Y N | Ulcers/Colitis |
| Y N | Heart Surgery/Pacemaker | Y N | Veneral Disease |

Please list any serious medical condition(s) that you have ever had: _____

_____

***ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?***

| | | | | | |
|---|---|---|---|---|---|
| Y N | Aspirin | Y N | Dental Anesthetics | Y N | Penicillin |
| Y N | Any Metals/Plastics | Y N | Erythromycin | Y N | Tetracycline |
| Y N | Codeine | Y N | Latex | Y N | Other |

Please list any other drugs/materials that you are allergic to: _____

_____

## 5 DENTAL HISTORY

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

_____

_____

Have you ever had or been evaluated for orthodontic treatment? ☐ Yes ☐ No

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

**Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)?** ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Have you ever had an injury to your: ☐ Mouth ☐ Teeth ☐ Chin

Do you have any speech problems? _____

Do you generally breathe through your mouth? ☐ Yes ☐ No

If yes, please circle: While awake? While Asleep?

Do you have any missing or extra permanent teeth? ☐ Yes ☐ No

Have you ever taken Fosamax, Actonel, Boniva or any other bisphosphonate?

Do you smoke or use tobacco in any form? ☐ Yes ☐ No

**I understand 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. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.**

_____

Signature Date

## ! *THANK YOU FOR FILLING OUT THIS FORM COMPLETELY.*

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

Signature _____ Date _____

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office.

Signature _____ Date _____

**Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.**

## OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally received the medical/dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

_____

_____