Orthodontics Exclusively

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Office Locations: Ft. Myers, Cape Coral & Lehigh Acres

NiceSmiles.com

DATE OF EXAM:

Patient's Information

NAME (LAST, FIRST, MI) | ❑ MALE ❑ FEMALE | BIRTHDATE | SOCIAL SECURITY NUMBER ___ ___

BILLING ADDRESS | HOME PHONE

CITY | STATE | ZIP CODE

EMPLOYER | E-MAIL | CELL PHONE | WORK PHONE

Spouse's Information

NAME (LAST, FIRST, MI) | | BIRTHDATE | SOCIAL SECURITY NUMBER ___ ___

BILLING ADDRESS | HOME PHONE

CITY | STATE | ZIP CODE

EMPLOYER | E-MAIL | CELL PHONE | WORK PHONE

Dental History

GENERAL DENTIST | DATE OF LAST EXAM

	YES	NO
Do you maintain 6 month dental check-ups?	❑	❑
Do your gums bleed while brushing?	❑	❑
Do you clench or grind your teeth?	❑	❑
Has your dentist suggested an orthodontic consultation?	❑	❑
Have you ever had an orthodontic consultation?	❑	❑
Have you ever had any orthodontic treatment?	❑	❑

COMMENTS:

HOW DID YOU HEAR OF OUR OFFICE?

❑ DENTIST ❑ INSURANCE COMPANY ❑ PHONE BOOK
❑ FRIEND _____ ❑ WEB SITE ❑ OTHER _____

NAMES OF ANYONE IN YOUR FAMILY WE HAVE SEEN

Insurance Information

DO YOU HAVE ORTHODONTIC INSURANCE? ❑ YES ❑ NO | NAME OF THE INSURANCE COMPANY | PHONE NUMBER

INSURED'S NAME | ❑ SELF ❑ SPOUSE ❑ _____ | SOCIAL SECURITY NUMBER ___ ___

Financial Information

NAME (LAST, FIRST, MI) OF PERSON RESPONSIBLE FOR PAYMENT

❑ SELF
❑ SPOUSE
❑ _____

SOCIAL SECURITY NUMBER ___ ___

BILLING ADDRESS

HOME PHONE

CITY

STATE

ZIP CODE

EMPLOYER

HOW LONG

POSITION

WORK PHONE

Medical Information

MEDICAL DOCTOR

DATE OF LAST EXAM

ARE YOU UNDER A DOCTOR'S CARE NOW?
❑ YES ❑ NO

FOR WHAT REASON?

HAVE YOU BEEN HOSPITALIZED IN THE LAST 5 YEARS?
❑ YES ❑ NO

FOR WHAT REASON?

ARE YOU ALLERGIC TO ANY MEDICATION?
❑ YES ❑ NO

IF YES, PLEASE LIST

ARE YOU TAKING ANY MEDICATION?
❑ YES ❑ NO

IF YES, PLEASE LIST

HAVE YOU EVER HAD:	YES	NO
Anemia	❑	❑
Diabetes	❑	❑
Epilepsy	❑	❑
Hepititis or HIV/AIDS	❑	❑
Rheumatic fever	❑	❑
Heart Murmur	❑	❑
Abnormal Heart Condition	❑	❑
Abnormal Bleeding from a cut	❑	❑
Abnormal Blood Pressure	❑	❑

ARE YOU ALLERGIC TO:	YES	NO
Penicillin	❑	❑
Local Anesthetic	❑	❑
Latex (Rubber Gloves)	❑	❑
Metals (ie. earrings)	❑	❑
Has patient ever taken any Diet Medication?	❑	❑
Bisphosphonate	❑	❑

COMMENTS

Patient's Signature _____

Doctor's Signature _____