RYCKMAN ORTHODONTICS

1. ABOUT YOU

Today's Date:_____

Name:_____
Last First M.I.

I prefer to be called:_____ ❑ Male ❑ Female

Birthdate: _____/_____/_____ Age:_____

Home Address:_____

_____
City State Zip

❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

Hm#:_____ Cell#:_____

Wk#:_____ Ext:_____

Email:_____

Employer:_____

Employer's Address:_____

Occupation:_____

Who may we thank for referring you?_____

Other family members seen by us?_____

General Dentist:_____

Last Visit Date:_____

Any Treatment Rendered?_____

2. SPOUSE INFORMATION

His/Her Name:_____

Cell#:_____

Email:_____

Employer:_____

Wk#:_____ Ext:_____

3. ACCOUNT HOLDER INFO

Person Responsible for Account:_____

Relationship:_____

Billing Address:_____

_____

Hm#:_____Cell#:_____

Email:_____

Employer:_____

Wk#:_____ Ext._____

4. ORTHODONTIC INSURANCE

Orthodontic Coverage? ❑Yes ❑ No

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone#:_____

Group#:_____

Insured's Name:_____

Relationship to Patient:_____

Insured's Birthdate:_____/_____/_____

Insured's SS# or Subscriber ID#_____

Insured's Employer:_____

Employer's Address:_____

Employer's Phone#:_____

Please let us know if you have a second eligible dental plan so that we can give you another form to fill out.

5. MEDICAL HISTORY

Local Emergency Contact Person

Name:_____ Relation:_____

Hm#:_____ Cell#:_____

Wk#_____

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name:_____

Phone #:_____

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 pregnant? ❑ Yes ❑ No Week #:_____

5. MEDICAL HISTORY *continued*

Have you ever had any of the following diseases or medical problems?

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

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

_____

_____

Are you allergic to any of the following?

Y N Aspirin
Y N Codeine
Y N Tetracycline
Y N Dental Anesthetics
Y N Any Metal/Plastic
Y N Erythromycin
Y N Penicillin
Y N Latex
Y N Other

6. DENTAL HISTORY

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

_____

_____

_____

Have you ever 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

Do your gums bleed? ❑ Yes ❑ No

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

Do you have any speech problems? Please describe:

_____

Do you generally breathe through your mouth?
❑ Y ❑ N Awake? ❑ Y ❑ N Asleep?

Do you have any missing or extra permanent teeth?
❑ 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

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

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally retrieved the medical / dental information above with the patient named herein.

Doctor's Comments Initials: _____ Date: _____

_____

_____

_____