LANGFORD
ORTHODONTICS

Welcome to our practice. To best serve you and make your first appointment as efficient as possible, we ask that you fill out all of the following information as completely as possible. We are looking forward to meeting you!!

PATIENT INFORMATION

Patient Name: ________________________________ Birth Date: _____________
Address: ____________________________________ City:__________________ ST: ____ ZIP: ______
Name of Person Responsible for Account: __________________________________ Relation: __________
Home Phone: ____________________________ OK to leave message? __________
Cell Phone: ______________________________ OK to leave message? __________

We have found that the best way to stay in contact is through texting – You can text us at any time using our office number (865-522-0121)

May we text information about patient appointments/treatment at this number? __________
Email: ____________________________
May we email information about patient appointments/treatment at this address? _________
Emergency Contact Name: ______________________ Number: _________________ Relation: ________

INSURANCE INFO

Primary Insurance: _____________________________ Phone Number: _________________
Group #______________________________ Member ID: _________________
Policy Holder's Name: ________________________ Relation: ________________
Policy Holder SS Number: ______________________ Policy Holder Birth Date: ______________
Policy Holder Employer: ______________________________ Work Phone: ____________
Secondary Insurance: ___________________________ Phone Number: _______________
Group #______________________________ Member ID: _________________
Policy Holder's Name: ____________________ Relation: _____________
Policy Holder SS Number: ______________ Policy Holder Birth Date: ______________
Policy Holder Employer: ______________________________ Work Phone: ____________

****Please describe your main concerns with your teeth and any information your dentist has given you about possible treatments: ____
____
____

DENTAL HISTORY for PATIENT

Dentist Name: ________________________ Have you visited an orthodontist before? ______________

[Yes / No] Please rate the patient's oral health: Good Fair Poor

Do you have regular dental check-ups? When was the last check-up? ________

Do you clinch/grind your teeth?

Do you have pain/tenderness/clicking in your jaw joint (TMJ), frequent headaches, ?

Do you have any of the following habits?

thumb sucking lip biting speech difficulty nail biting mouth breathing

Have you had an injury to your neck, jaw or teeth?

Explain: ____

Has anyone in your family had braces? _____ Name and relationship:______________________

Anyone else in the family you would like us to evaluate while you are here?_________________

MEDICAL HISTORY for PATIENT

[Yes / No] Please rate your overall health: Good Fair Poor

Are you currently being treated by a physician? Reason: ________________________

Physician Name: ____________________ Phone Number: ____________________

Are you taking any prescription or over-the-counter drugs?

List: ____

Are you allergic to any drugs or other substances (including heavy metals or latex)?

List: ____

Have you ever experienced the following medical conditions? (circle any that apply)

Abnormal bleeding	Aids	Anemia
Asthma	Cancer	Chicken Pox
Congenital Heart Defect	Convulsions	Diabetes
Epilepsy	Heart Murmur	Hemophilia
Hepatitis	High Blood Pressure	HIV+
Kidney problems	Low Blood Pressure	Rheumatic Fever
Skin rashes	Tuberculosis (TB)	Tonsillitis

Are you currently Pregnant or Nursing?

Are there any other medical conditions we should be aware of?

Explain: ____

Has your physician told you that you need to be premedicated with an antibiotic before dental procedures? ____________ If yes, what is the medical condition and what is the antibiotic?____

AUTHORIZATION

I understand that the information provided today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is MY responsibility to inform the office of any changes in my medical status.

I hereby authorize the release of any information pertaining to my medical treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payments of any benefits to the office of Langford Orthodontics. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE (FOR ANY REASON).

Signature of Patient/Responsible Party: ______________________________ Date: ________________

** We have found that the best way to communicate with our patients is through email or texting. You may text us at any time by using our office number (865-522-0121). We are often able to communicate with you more efficiently through texting – without interfering with your day.

May we text information about patient appointments, treatment, and financial status to the Cell Phone number provided?

Best Cell Number to Text: _________________________

Name associated with that Cell Number: _________________

Signature giving OK to text information : ______________________________ Date: ________________