KEYSER Orthodontics
Live Life Smiling

Welcome

We would like to welcome you to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. Thank you for your cooperation.

Patient Information

Patients Name:_____ Date of Birth:_____
First Middle Last

Nickname (if preferred): _____ Social Security Number: _____

Martial Status: Single Married Widowed Divorced Separated Sex: Male / Female

Mailing Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone:_____

Employer: _____ Occupation: _____

Spouse's Information

Spouse's Name:_____ Date of Birth:_____
First Middle Last

Nickname (if preferred): _____ Social Security Number: _____

Martial Status: Single Married Widowed Divorced Separated Sex: Male / Female

Mailing Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone:_____

Employer: _____ Occupation: _____

Insurance

If you have insurance coverage, please fill out below:

Insurance Company Name:_____ Insurance Phone Number:_____

Insurance Company Address:_____

Plan/ Group ID #:_____ Member ID #:_____

Do you have a secondary insurance policy? Yes / No

Medical History

Are you currently under the care of a physician for a medical reason? Yes No What reason:_____

Physician's Name:_____ Phone:_____

History of major illness? Yes No If Yes, please describe:_____

History of hospitalization? Yes No If Yes, please describe:_____

History of surgery? Yes No If Yes, please describe:_____

Any sensitivities or allergies? Yes No If Yes, please list_____

Currently taking any medications? Yes No If Yes, please list_____

Please circle if you currently or have a history of any of the following:

Severe headaches	Deviated septum of nose	High blood pressure	Convulsions/Seizures
Sinus trouble	Anemia	Hepatitis	Veneral disease
Frequent colds	Bleeding problems	HIV/AIDS	Speech problems
Persistent cough	Tuberculosis	Liver disease	Behavior problem
Tonsilitis	Rheumatic fever	Kidney disorder	Emotional problems
Frequent sore throat	Any joint problems	Diabetes	Other: _____
Operation or injury to teeth/jaw	Heart disease	Endocrine disturbance	

Dental History

Patient's General Dentist:_____ Last Dental Cleaning:_____

Have you ever seen an orthodontist before? Yes No If Yes, Practice Name: _____

Have we treated another member of your family? Yes No If Yes, Name _____
First Last

Whom can we thank for referring you to our office? _____

Do you require antibiotics before dental treatment? Yes No If Yes, please explain _____

Do you grind your teeth or clinch your jaws? Yes No If Yes, Do you wear anything between your teeth? Yes No

Do you have any popping/clicking of your jaw joints? Yes No If Yes, which side?_____

Have you ever had any pain/tenderness in the jaw joint (TMJ/TMD)? Yes No If Yes, which side? _____

Have you ever been told you had any extra or missing permanent teeth? Yes No

Does any member of the family have a similar arrangement of teeth or appearance of jaws? Yes No

Have you had any injuries to your face, mouth or chin? Yes No

Why are you seeking treatment?_____

Did or do you have any of the following habits?
Finger/Thumb sucking Mouth breather Speech problems Chewing/eating problems

Please circle if you have a history of any of the following?

Removal of permanent teeth (besides wisdom teeth)	Root canal work	Gum disease and/or treatment
Sensitive teeth	Implants	Previous orthodontic treatment
Sore, bleeding gums	Other extensive dental treatment	

Authorization and Signature

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

I hereby authorize release of any information related to insurance claims. I consent to examination by the doctor, radiographs for treatment purposes and I authorize payment of any insurance benefits to the office.

Signature _____ Date _____