BATTISTONI AND BEAM ORTHODONTICS

Date: _____ Confidential Patient Information - Adult A B C

Name: _____ M/ S / D/ W
Last First Middle Nickname Marital Status

Date of Birth: _____ Age:_____ Social Security # _____

Address: _____
Street City State Zip

How long at the above address? _____ Own / Rent

Previous address if less than 3 Years _____
Street City State Zip

Cell Phone #:_____Home Phone #: _____
Email: _____

Employer: _____Occupation:_____Yrs. Employed: _____

List any family members seen by our practice: _____

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

General Dentist: _____ Office #: _____

Confidential Responsible Party/Spouse Information

Name: _____
Last First Middle

Date of Birth: _____ Age:_____ Social Security #: _____

Employer: _____Occupation:_____Yrs. Employed: _____

Dental Insurance Information

Policy holder:_____ Relation to patient:_____
Insurance Company: _____ Phone #: _____
Insurance Co. Address: _____
Group #:_____Insured ID#:_____ Union Local #:_____

Do you have Dual Insurance **Yes or No** If Yes: Policy Holders Name: _____
Insurance Company: _____ Phone #: _____
Insurance Co. Address: _____
Group #:_____Insured ID #:_____ Union Local #: _____

Emergency Information

Emergency Contact: _____ Phone #: _____
Address: _____ Relation to Patient: _____

Medical History - Name: _____Date: _____

Has the patient had any of the following medical problems? Please circle Y/N for each medical condition listed.

Heart disease/problems	Y N	Heart Murmur	Y N	Cancer /Radiation	Y N
Chemotherapy	Y N	Diabetes	Y N	High/low Blood Pressure	Y N
Anemia	Y N	Hives/Rash	Y N	Dizziness/ Fainting/ Seizures	Y N
Asthma	Y N	Hepatitis A, B, or C	Y N	Hemophilia/Abnormal Bleeding	Y N
Osteonecrosis of jaw	Y N	Lung disease	Y N	Tuberculosis	Y N
Breathing problems	Y N	Epilepsy	Y N	Tumors/growths	Y N
Kidney /liver problems	Y N	Shingles	Y N	Rheumatism / Arthritis	Y N
AIDS/HIV	Y N	Nervousness	Y N	Herpes /Venereal Disease	Y N
Fever Blister	Y N	Allergies	Y N	Alcoholism/ Drug Addiction	Y N
ADD/ADHD	Y N	Tobacco Use	Y N	Stomach/intestinal disease/ulcers	Y N

Are there any allergies to any of the following?

Penicillin	Y N	Tetracycline	Y N	Anesthetics	Y N	Erythromycin	Y N
Metal/plastic	Y N	Aspirin	Y N	Codeine	Y N	Latex	Y N

Other: _____

Are you currently being treated by a physician? Y N If yes, please explain _____

Please list any prescription, OTC drugs or vitamins being taken: Y N _____

Have the tonsils and/or adenoids been removed? Y N _____

What is your current health condition? Good / Fair / Poor _____

Are you aware of any missing/extra teeth? Y N _____

Any past or present discomfort/clicking in the jaw joint? Y N _____

Have you ever been told you need antibiotics prior to dental treatment? Y N _____

Any past injuries to the Mouth? Y N Chin? Y N Teeth? Y N Explain: _____

Do any of the following habits apply?

Speech problems	Y N	Constant mouth breathing	Y N	Lip/cheek biting	Y N
Clenching / Grinding teeth	Y N	Tongue thrust swallow	Y N	Thumb/Finger	Y N

Please list any medical condition not listed above: _____

Female Patients: Is there any possibility of pregnancy? Y N

Orthodontic Information

What would you like orthodontic treatment to accomplish? _____

Have you ever been evaluated by an orthodontist or had orthodontic treatment before / currently? _____

_____

- *For those already in treatment, transferring orthodontic treatment care to our office* -

Your previous orthodontic provider was an ☐ Orthodontist ☐ Family Dentist

Previous Doctor's Name: _____ Address: _____

City: _____State:_____Zip:_____Phone #: _____

Are your orthodontic records: With you? Y N Currently being shipped to us? Y N Still at the above Doctor's office? Y N

To the best of my knowledge the preceding answers are correct. I will inform the doctor and staff at the next appointment if there are any changes to my health status or medications.

This Office reserves the right to verify the credit status of potential patients prior to extending credit for treatment fees. While the office accepts insurance, I understand that I am responsible for payment of services rendered.

Patient's signature: _____ **Date** _____

Updates (date & initial) _____

FOR OFFICE USE

Medical History reviewed	_____/_____		_____/_____		_____/_____		_____/_____	
	Initials	Date	Initials	Date	Initials	Date	Initials	Date

Comments _____

_____