Piper Orthodontics

901-756-4316 PiperOrtho.com
Fred Piper DDS, MS, PC
Specialist in Orthodontics

1. ABOUT YOU

Today's Date:____/____/____

Name: _____
Last First MR MRS MS DR

I prefer to be called:_____ MI ☐ Male ☐ Female

Birthdate:___/___/___ Age:____ SS#: _____

Home Address: _____
Apt / Condo #

_____
City State Zip

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (____)_____ Mobile #: _____

Wk #: (____)_____ Ext._____ DL#: _____

EMAIL: _____

Employer: _____

Employer's Address: _____

How long there?_____ Occupation: _____

Where & when are best time to reach you? _____

How did you hear about our practice? _____

☐ Referred by Dentist
(If yes, who?) _____

☐ Existing Patient
(If yes, who?) _____

☐ Internet Search

☐ Other _____

General Dentist: _____

Address: _____

Last Visit Date: _____

2. SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

Wk #: (____)_____ Ext.____ SS#: _____

Birthdate: ___/___/___

Person Responsible for Account: _____

Wk #:_____ Ext._____ Hm #: _____

Billing Address: _____

Relation:_____ SS#: _____

Employer: _____

3. ORTHODONTIC INSURANCE

Primary Insurance:

Orthodontic Coverage? ☐ Yes ☐ No Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____ Relation: _____

Address:_____ Phone #:_____

Insured's Birthday: ___/___/___ Insured's SS#: _____

Insured's Employer: _____

Secondary Insurance:

Orthodontic Coverage? ☐ Yes ☐ No Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____ Relation: _____

Address:_____ Phone #:_____

Insured's Birthday: ___/___/___ Insured's SS#: _____

Insured's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name:_____ Relation: _____

Wk #: (____)_____ Hm #: (____)_____

CONTINUED ON BACK

4. DENTAL HISTORY

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

_____

Have you ever had or 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

Gums ever bleed? ❑ Yes ❑ No

Have you ever had an injury to your: Mouth Teeth Chin (please circle)

Do you have any speech problems? _____

Do you generally breathe through you mouth? ❑ Yes ❑ No

If yes, please circle: While Awake? While Asleep?

Do you have any missing or extra permanent teeth? ❑ Yes ❑ No

Do you clench or grind teeth? ❑ Yes ❑ No

If yes, when? _____

5. MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: _____

Phone #: (_____)_____ Date of last visit: _____

6. MEDICAL HISTORY (continued)

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you taking any prescription / over-the-counter drugs? ❑ Yes ❑ No

Please list each one: _____

For Women:

Are you pregnant? ❑ Yes ❑ No Week #:_____

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

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

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

_____

Are you allergic to any of the following:

Y	N	Aspirin	Y	N	Dental Anesthetics	Y	N	Penicillin
Y	N	Any Metals/Plastics	Y	N	Erythromycin	Y	N	Tetracycline
Y	N	Codeine	Y	N	Latex	Y	N	Other

Please list any other drugs / materials that you are allergic to: _____

_____

THANK YOU FOR FILLING OUT THIS FORM COMPLETELY.

This office reserves the right to verify the credit status of potential patients and / or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

_____

Signature Date

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

_____

Signature Date

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

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE**

I verbally reviewed the medical / dental information above with the parent / guardian and patient name herein.

Initials:_____ Date:_____

Doctor's Comments: _____

_____

_____