

Date _____ Referred by _____
 Patient _____ Home Phone _____
 Address _____ Cell Phone _____
 City _____ State _____ Zip _____
 Employer _____ Work Phone _____
 Date of Birth _____ Age: _____ Sex: Male Female Email Address _____
 Single Married Spouse's Name _____
 Person to call in case of emergency _____ Phone No. _____

INSURANCE INFORMATION

Primary Dental Insurance _____
 Ins. Co. Ph. # _____
 Group# / Employer _____
 Name of Subscriber _____
 Date of Birth _____ Soc. Sec. # _____

Secondary Dental Insurance _____
 Ins. Co. Ph. # _____
 Group# / Employer _____
 Name of Subscriber _____
 Date of Birth _____ Soc. Sec. # _____

MEDICAL INFORMATION

Are you allergic to: Penicillin? Sulphur Drugs?
 Codeine? Latex? Other _____
 Are you taking any medications? _____
 For what purpose? _____
 Are you under the care of a physician? Y N
 Date of last medical exam _____
 (Women) are you pregnant? Y N
 Due Date _____

MEDICAL HISTORY

Do you or have you ever had?

- Y N Heart disease / defect / murmur
- Y N Rheumatic Fever
- Y N Diabetes
- Y N Cancer or Tumor
- Y N High Blood Pressure
- Y N Epilepsy / Convulsions
- Y N Tuberculosis or Lung Disease
- Y N Asthma or Hay Fever / Allergies
- Y N Sinus Trouble
- Y N Hepatitis, Jaundice or Liver Trouble
- Y N Venereal Disease
- Y N Immune Deficiency or HIV
- Y N Surgery
- Y N Kidney Disease
- Y N Prolonged Bleeding
- Y N Anemia
- Y N Other

Notes _____
 Physician _____ City _____
 Dentist _____ City _____

I, the undersigned certify that I have insurance coverage with the above named insurance company(s) and assign directly to Dr. John C. Ive all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible party signature _____ Relationship _____ Date _____

Your answers to the following questions will be helpful in the planning of orthodontic treatment and will be kept confidential.

Why are you seeking orthodontic treatment? _____

DENTAL HISTORY

	Yes	No
Do you require premedication for dental appointments?	_____	_____
Do you have difficulty chewing food?	_____	_____
Have you ever been told you have periodontal or gum disease?	_____	_____
Do you clench or grind your teeth at night or at other times?	_____	_____
Do you have frequent headaches?	_____	_____
Do you frequently have tired or sore jaw muscles?	_____	_____
Do you have difficulty opening your mouth wide?	_____	_____
Are you dissatisfied with the appearance of your teeth?	_____	_____
Have you experienced jaw joint problems (pain, clicking, popping, etc.)?	_____	_____
Is there anything else in your medical or dental history you feel we should be aware of?	_____	_____

Describe: _____

DX: FACE _____
 A-P _____
 TRANS _____
 VERT _____
 PERIMETER MX _____
 MN _____
 PERIO _____

	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
r																
					R				L							
	TMJ															
	NOISE															
	PAIN JOINT															
	MX OPEN															
	LAT															
	DEVIATION															

DX SUMMARY _____

PROPOSED TX _____

 EST. TX TM _____
 EST. TX FEE _____

TX this DATE / FEE _____
 DISPOSITION: Recs _____