ABO Board Certified Orthodontic Specialists

Offices in Layton and Clinton Utah

Welcome to our office. We do whatever it takes to put a smile on your face. Please help us get to know you by filling out the following information.

PATIENT INFORMATION

Name ____________________Today's Date ___/___/___
Nickname____
Birth date _____/_____/_____ Age______ M___ F___
Address ____
City _______________ State______ Zip code_________
How long at this address___________________________
Home phone ______________________________________
Dentist-First and Last name_________________________
Last visit ____
Favorite sports or hobbies __________________________
School __________________________ Grade _________
Parent or legal guardian ___________________________
Patient's residence: both parents___ mother___ father___
Are parents M____ S____ D____ W____
Other____
Incase of emergency contact _________________________
Phone # ________________ Relationship _____________

INSURANCE INFORMATION ___Y ___N

Primary insurance company_______________________
Insured name ____________________________________
Contact # ______________________ Group # _________
Subscriber # _______________ Employer ____________
Coverage amount _____% up to _____ max _____ deduct
Secondary insurance company ____________________
Insured name ________________ Birth date ___/___/___
Contact # ______________________Group # __________
Subscriber # _______________ Employer ____________
Coverage amount _____% up to _____ max _____ deduct
Third insurance company ________________________
Insured name ____________________________________
Contact # ______________________ Group # _________
Subscriber # _______________ Employer ____________
Coverage amount _____% up to _____ max ______deduct

I have been informed of the treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X____
Patient/Guardian signature Date

I hereby authorize and direct payment of dental benefits otherwise payable to me, directly to Coombs Orthodontics.

X____
Subscriber signature Date

WHO REFERRED YOU TO OUR OFFICE

___ Dentist ______________________________________
___ Friend _______________________________________
___ Yellow pages __________________________________
___ Internet ______________________________________
___ Other ____

MOTHER'S INFORMATION

Mom________ Step Mom ________ Guardian________
Name ______________________ Birth date____/____/____
Address ____
City __________________ State ______ Zip code ________
Home # _________________ Work # __________________
Employer _____________________ Job title ____________
No. of years employed ____________
SSN _________________________ Cell # ______________
E-mail address ____________________________________

FATHER'S INFORMATION

Dad ________ Step Dad________ Guardian________
Name _____________________ Birth date ____/____/____
Address ____
City _______________ State _____ Zip code ____________
Home # ________________ Work # ___________________
Employer ___________________ Job title ______________
No. of years employed ___________
SSN _____________________ Cell # __________________
E-mail address ____________________________________

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Name __________________ Relationship ______________
Address ____
City _______________ State ______ Zip code ___________
Home # __________________ Work # _________________
Employer ___________________ Job title ______________
SSN ______________________ Birth date ______________

Do you participate in the following?

Facebook ___ Twitter ___ Blog ___ LinkedIn ___ Other___

We would love to connect with you online!

www.coombssmiles.com
www.facebook.coombsorthodonticsutah.com
www.coombsorthodonticsutah.blogspot.com

MEDICAL HISTORY

Physician ______________________ Date of last visit ______________________

Address ______________________ Phone ______________________

Please circle Yes or No (if yes please fill in details)

Yes No Are you presently taking any medication? ______________________

Yes No Are you allergic to any medication? ______________________

Yes No Do you have a history of a major illness? ______________________

Yes No Have you had any major operations? ______________________

Yes No Have you ever been involved in a serious accident? ______________________

Yes No Do you presently or have you ever used tobacco? ______________________

Please circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/hemophilia	Diabetes	Hepatitis/liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High blood pressure	Radiation/chemotherapy
Asthma or hay fever	Gastrointestinal disorders	HIV/Aids	Rheumatic fever
Bone disorders	Heart problems	Kidney problems	Tuberculosis
Congenital heart defect	Heart murmur	Nervous disorders	Tumor or cancer

Any other medical condition we should be aware of ______________________

____

DENTAL HISTORY

What concerns you most about your teeth? ______________________

____

Please circle Yes or No (if yes please fill in details)

Yes No Are you presently in any dental pain? ______________________

Yes No Have you ever experienced any unfavorable reaction to dentistry? ______________________

Yes No Have you ever lost or chipped any teeth? ______________________

Yes No Is any part of your mouth sensitive to temperature or pressure? ______________________

Yes No Do your gums bleed when you brush or floss? ______________________

Yes No Do you have any type of thumb or tongue habit? ______________________

Yes No Are you a mouth breather? ______________________

Yes No Have you ever seen an orthodontist? If yes, who and when? ______________________

Yes No Would you object to wearing orthodontic appliances (braces) should they be indicated? ______________________

Yes No Has anyone in your family received orthodontic treatment? ______________________

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? ______________________

Yes No Are you aware of your jaw clicking or popping? ______________________

Yes No Are you aware of clenching your teeth during the day? ______________________

Yes No Have you ever been told that you grind your teeth? ______________________

Yes No Do you have "tension" headaches? ______________________

Yes No Have you ever experienced chronic ringing in your ears? ______________________

Yes No If the patient is under age 16, height of parents ________ mom ________ dad

Yes No Are you aware that some appointments will be during school/work hours? ______________________

Female patients only:

Yes No Are you pregnant? ______________________

Yes No Has patient reached puberty? ______________________ If so at what age? ______________________

BENEFITS

Benefits of orthodontic treatment: Aesthetics, health, and function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Coombs to perform a complete orthodontic evaluation.

____
Please print name of person filling out these forms.

____
Relationship to patient

____
Signature

____
Date