FLUSHING ORTHODONTICS

5255 W. Pierson Road, Flushing, MI 48433
(810) 733-6605

About You

Today's Date: _____/_____/_____ □ Male □ Female

Name:_____
LAST FIRST MI

Preferred Name:_____Marital Status: S M D W

Birthdate:_____/_____/_____ Age:_____ SSN:_____

Address:_____

_____
CITY STATE ZIP

Email:_____

Employer:_____

How long there?_____ Occupation:_____

Home Phone:_____ Cell:_____

Work Phone:_____

Whom may we thank for referring you:

_____

Preferred appointment reminder method:

□ Email _____

□ Text #_____

In the event of an emergency, whom would you like us to contact?

His/Her Name:_____

Relation: _____

Home Phone:_____ Cell:_____

Insurance Information

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone : _____

Insured's ID #: _____

Group #: _____

Insured's Name: _____

Insured's Birthdate: _____/_____/_____

Secondary Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: _____

Insured's ID #: _____

Group #: _____

Insured's Name: _____

Insured's Birthdate: _____/_____/_____

Spouse Information

His/Her Name: _____

Employer: _____

Work Phone:_____Cell:_____

Birthdate: _____/_____/_____

(PLEASE COMPLETE BACK OF FORM)

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Dental and Medical History

General Dentist:_____ Phone:_____

Address:_____

Last cleaning:____/____/____ Have you ever been evaluated for or had orthodontic treatment before: Y / N

What are the main concerns that you would like orthodontics to accomplish:_____

_____

Do you or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Y / N

Grind teeth : Y / N Mouth Breather: Y / N Missing Teeth: Y / N

Have □ Tonsils □ Adenoids been removed?

Have you experienced any unfavorable reaction from any previous dental or medical care? Y / N

Do you require antibiotics before dental procedures? Y / N

If yes, please specify and give reason for this need: _____

Family Physician:_____ Phone: _____

Address:_____

Are you currently under a physician's care? Y / N If yes, explain: _____

Are you taking any medicine at this time? Y / N Please specify: _____

Are you allergic to any medication? Y / N Please specify: _____

Do you have any known allergies? Y / N Please specify: _____

Have you been hospitalized or had any surgeries?? Y / N Please specify:_____

Do you have any history of these (Circle all that apply)?:

Yes / No Allergies	Yes / No Lung Disorder	Yes / No Heart Disorder/Murmur	Yes / No Speech Difficulties
Yes / No Anemia	Yes / No Breathing difficulties	Yes / No Hypertension	Yes / No Emotional Disorders
Yes / No Prolonged bleeding/Clotting Disorder	Yes / No Asthma	Yes / No Congenital Heart Disease	Yes / No Hearing difficulties
Yes / No Bone Problem or Disorder	Yes / No Bronchitis	Yes / No Rheumatic fever	
Yes / No Arthritis/Joint Swelling	Yes / No Tuberculosis	Yes / No Endocrine/Hormone disorders	
Yes / No Artificial Joint	Yes / No Neurologic disorder	Yes / No Diabetes	
Yes / No AIDS or HIV	Yes / No Cerebral palsy	Yes / No Hepatitis or Liver Disorder	
Yes / No ADD/ADHD	Yes / No Convulsions/ Seizures	Yes / No Kidney or bladder Disorder	

If you are experiencing or have a history of any disease, condition or problem not addressed, please explain:

_____

Signature: _____ **Date**: _____