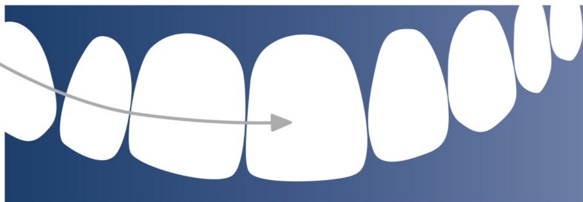

SURBECK ORTHODONTICS

WELCOME TO OUR OFFICE

So that we might become better acquainted, please complete **both** sides of this form.

ADULT PATIENT INFORMATION

Patient's Name: ______________________ Preferred Name: ______________ ❐ Female ❐ Male

First M.I. Last

Home Address: ______________________ City/State: ______________ Zip: __________

Birth date: _____/_____/_____ Age: ______

Employer: ______________ Occupation: ______________ # of years employed: ________

Home Phone: (_____) ______ - ________ Cell Phone: (_____) ______ - _________ Email: ______________

Marital Status: ❐Single ❐Married ❐Separated ❐Divorced ❐ Widowed

Spouse's Name: ______________________ Birth date: / /

Spouse's Employer/Occupation: ______________________ Spouse's Cell: ( ) -

Person responsible for account: ______________________

Who referred you and/or how did you find out about our office? ______________________

Do you know a patient currently in our practice? If so, who? ______________________

List all other family members who have received orthodontic treatment in our office: ______________________

We will gladly assist you in submitting your insurance claims. Release of benefits and information: I authorize my insurance benefits to be paid directly to Dr. Burleigh Surbeck and that I am financially responsible for any balance due. I authorize Dr. Surbeck or the insurance company to release any information required for this claim. I recognize that the New Patient Adult Exam fee is $50, which I will pay should my insurance not cover the exam.

Policy Holder's Name: ______________________ ID/SS # ______________ Birth date: _______/_______/_______

Insurance Company: ______________ Group # ______________ Phone # ______________

Employer: ______________________

Policy Holder's Name: ______________________ ID/SS# ______________ Birth date: _______/_______/_______

Insurance Company: ______________ Group # ______________ Phone # ______________

Employer: ______________________

Signature: ______________________ Date: ______________

Please complete the backside of this form.

FOR OFFICE USE ONLY:

Benefit Amount $ ______________ Benefit Used $ ______________ Deductable $ ______________ Age Limit: ______

Method of Payment ❐ Monthly ❐ Quarterly ❐ Annual ❐ Other Continuation Form ❐ YES ❐ NO

Confirmed on: / / By: ______________________

375 118th Ave SE, Suite 100, Bellevue, WA 98005 425-455-1944 www.surbeckortho.com

Dentist Name: ______________________ ______________ (city) Approximate date of last check-up ______ (mo) ______ (yr)

Dental Specialist's Name: ______________________ ______________ (city) Approximate date of last visit ______ (mo) ______ (yr)

Who first noticed the orthodontic problem? ❒ Patient ❒ Dentist ❒ Other ______________

Have you had any previous orthodontic treatment? ❒ NO ❒ YES If yes, with whom? ______________ At what age? ______

Satisfied? ______________

Have you consulted an orthodontist previously? ❒ NO ❒ YES If yes, with whom? ______________

What are your chief concerns you have related to the position of your teeth or bite:

- ❒ Appearance / Smile
- ❒ Comfort / Bite
- ❒ Stability / Shifting
- ❒ Jaw Joint / Muscle discomfort
- ❒ Difficulty cleaning / Gum Problem
- ❒ Ability to Chew / Function
- ❒ Wear / Fractures of Teeth
- ❒ Alignment of teeth prior to restoration of dental work (crowns, implants, etc.)

DENTAL HISTORY

Question			
Do you have a fear of dental treatment?	❒ NO	❒ YES	Explain: ______________
Have you had an unpleasant experience in a dental office?	❒ NO	❒ YES	Explain: ______________
Is there any unfinished care to be completed by your dentist?	❒ NO	❒ YES	Explain: ______________
Has there been any injuries to the face, mouth, chin or teeth?	❒ NO	❒ YES	Explain: ______________
Have you had any baby or permanent teeth removed?	❒ NO	❒ YES	Explain: ______________
Have you been informed of any missing or extra permanent teeth?	❒ NO	❒ YES	Explain: ______________
Do you have difficulty chewing or swallowing food?	❒ NO	❒ YES	Explain: ______________
Do you have any speech problems or tongue thrust?	❒ NO	❒ YES	If yes, what sounds? ______________
Do you grind or clench their teeth while sleeping or awake?	❒ NO	❒ YES	❒ AWAKE ❒ ASLEEP
Have you ever sucked a thumb or finger?	❒ NO	❒ YES	If yes, until what age?_____ Currently? ______
Do you frequently breathe through your mouth?	❒ NO	❒ YES	❒ AWAKE ❒ ASLEEP
Do you have any clicking, popping or soreness of the jaw joint?	❒ NO	❒ YES	Explain: ______________

MEDICAL HISTORY

Question			
Do you have any allergies? **(ex: medications, foods, latex, bees)**	❒ NO	❒ YES	Explain: ______________
Are you currently taking any medication?	❒ NO	❒ YES	Explain: ______________
Have you experienced any health problems?	❒ NO	❒ YES	Explain: ______________
Any major changes in your health recently?	❒ NO	❒ YES	Explain: ______________
Are you currently under physician's care?	❒ NO	❒ YES	Explain: ______________
Have your tonsils or adenoids been removed?	❒ NO	❒ YES	Explain: ______________
Have you ever received a blood transfusion?	❒ NO	❒ YES	Explain: ______________
Have you ever been in a risk group for aids?	❒ NO	❒ YES	Explain: ______________

Please check *ONLY* if you have had any of the following conditions:

- ❒ Heart Murmur
- ❒ Heart Surgery
- ❒ Artificial Valves/Stents
- ❒ Rheumatic fever
- ❒ Endocrine Disorder
- ❒ Prolonged Bleeding
- ❒ Anemia
- ❒ Blood Disease
- ❒ Development Disorder
- ❒ Hives/Rash
- ❒ Artificial Joints
- ❒ Hepatitis A (infectious)
- ❒ Hepatitis B
- ❒ Hepatitis C
- ❒ Diabetes
- ❒ Kidney Disease
- ❒ Liver Disease
- ❒ Tuberculosis
- ❒ Bronchitis
- ❒ Asthma
- ❒ Epilepsy
- ❒ Fainting
- ❒ Emotional problems
- ❒ Frequent Headaches
- ❒ Nervous/ Anxious
- ❒ Shortness of Breath
- ❒ Cancer
- ❒ Bone Disorder
- ❒ Growth Disorder
- ❒ Herpes (Fever Blisters)
- ❒ Tonsillitis
- ❒ HIV Positive (AIDS)

Is there any other condition that you think we should know about?______________________________

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status.

Signature ______________________________ Date ___/___/___