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: _____ Soc. Sec. #: _____ - ____ - _____

Employer: _____ Occupation: _____ # of years employed: _____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____ Email: _____

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

Spouse's Name: _____ Birth date: ___/___/___ Soc. Sec. #: _____ - _____ - _____

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 # _____ Birth date: _____/_____/_____

Insurance Company: _____ Group # _____ Phone # _____

Employer: _____

Policy Holder's Name: _____ ID# _____ 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: _____

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

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

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 ____ / ____ / ____