BRIAN SCOTT *D.D.S., M.S., P.C.*
Scott Family Orthodontics
orthodontics exclusively

Member American Association of Orthodontists

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Welcome To Our Office

PATIENT'S NAME _____ NAME PATIENT GOES BY _____
Last First Middle

HOME ADDRESS _____ HOME PHONE _____
Street City State Zip

BIRTHDATE_____ AGE _____ SEX _____ SCHOOL & GRADE _____
Mo. Day Yr.

PATIENT'S INTERESTS: SPORTS, HOBBIES, MUSIC, CHURCH OR SCHOOL ACTIVITIES _____

BROTHERS: AGE: _____ SISTERS: AGE: _____ CIRCLE AGES THAT HAVE HAD OR ARE HAVING ORTHODONTIC TREATMENT

PATIENT'S DENTIST _____ PATIENT'S PHYSICIAN _____ REFERRED BY _____

CLOSE FRIEND OR RELATIVE WHO IS A PATIENT IN THIS OFFICE_____

WHO IS RESPONSIBLE FOR ACCOUNT? _____

❑ FATHER ❑ STEPFATHER ❑ GUARDIAN

❑ SINGLE ❑ MARRIED ❑ WIDOWED ❑ DIVORCED ❑ SEPARATED

NAME: _____

BIRTHDATE:_____/_____/_____

ADDRESS: (IF DIFFERENT THAN CHILD'S)

_____

_____ HM# (____) _____

SS#: _____ DL#: _____

WK#: (____)_____ CELL#: (____) _____

EMAIL: _____

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____

_____
CITY STATE ZIP

❑ MOTHER ❑ STEPMOTHER ❑ GUARDIAN

❑ SINGLE ❑ MARRIED ❑ WIDOWED ❑ DIVORCED ❑ SEPARATED

NAME: _____

BIRTHDATE:_____/_____/_____

ADDRESS: (IF DIFFERENT THAN CHILD'S)

_____

_____ HM# (____) _____

SS#: _____ DL#: _____

WK#: (____)_____ CELL#: (____) _____

EMAIL: _____

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____

_____
CITY STATE ZIP

WHOM SHALL WE CONTACT IF UNABLE TO REACH MOTHER OR FATHER? _____
Name Relationship Phone

IF YOU HAVE ORTHODONTIC INSURANCE COVERAGE FOR THE CHILD, PLEASE FILL OUT BELOW:

INSURANCE CO. NAME: _____

INSURANCE ADDRESS: _____

_____
CITY STATE ZIP

INS. PH#: (____) _____ INSURED'S ID#: _____

GROUP# (PLAN, LOCAL OR POLICY#):_____

IF YOU HAVE ORTHODONTIC INSURANCE COVERAGE FOR THE CHILD, PLEASE FILL OUT BELOW:

INSURANCE CO. NAME: _____

INSURANCE ADDRESS: _____

_____
CITY STATE ZIP

INS. PH#: (____) _____ INSURED'S ID#: _____

GROUP# (PLAN, LOCAL OR POLICY#):_____

AUTHORIZATION

THIS OFFICE RESERVES THE RIGHT TO VERIFY THE CREDIT STATUS OF POTENTIAL PATIENTS AND/OR PARENTS OF PATIENTS PRIOR TO EXTENDING CREDIT FOR TREATMENT FEES AND MAY, AT THE DISCRETION OF THIS OFFICE, USE THE SERVICES OF ONE OR MORE CREDIT REPORTING SERVICES. ADDITIONALLY, I HEREBY AUTHORIZE DR. SCOTT TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF INSURANCE BENEFITS, AND I ASSIGN DIRECTLY TO THE DOCTOR ALL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I FURTHER AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS, WHETHER MANUAL OR ELECTRONIC.

_____ _____
SIGNATURE OF PARENT OR GUARDIAN **DATE**

MEDICAL HISTORY

	YES	NO
IS THE PATIENT IN GOOD HEALTH?	❑	❑
IS THE PATIENT UNDER PHYSICIAN'S CARE?	❑	❑
IF SO, FOR WHAT REASON_____		
ARE THERE ANY IMPENDING OPERATIONS?	❑	❑
IF SO, PLEASE DESCRIBE_____		
IS THE PATIENT TAKING PRESCRIPTION MEDICATIONS?	❑	❑
IF SO, PLEASE LIST _____		
IS THE PATIENT ALLERGIC TO MEDICINES?	❑	❑
IF SO, PLEASE LIST _____		
HAS PUBERTY BEEN REACHED (START OF MENSTRUATION OR VOICE CHANGE)?	❑	❑
IF SO AND WITHIN LAST 2 YEARS, WHEN? _____		
DOES PATIENT TAKE HERBAL MEDICINES?	❑	❑
IF SO, PLEASE LIST _____		

FOR FEMALES ONLY:

IS THE PATIENT PRESENTLY PREGNANT?	❑	❑
DOES THE PATIENT TAKE BIRTH CONTROL PILLS?	❑	❑

HAS PATIENT HAD OR CURRENTLY HAVE ANY OF THE FOLLOWING:	YES	NO	"Office Use Only"
AIDS/HIV+	❑	❑	_____
ALLERGIES TO:			
METALS	❑	❑	_____
VINYL	❑	❑	_____
LATEX	❑	❑	_____
ACRYLIC	❑	❑	_____
SEASONAL	❑	❑	_____
OTHER _____	❑	❑	_____
ANEMIA	❑	❑	_____
ARTHRITIS	❑	❑	_____
ASTHMA	❑	❑	_____
BONE DISORDERS	❑	❑	_____
CIRCULATORY PROBLEMS	❑	❑	_____
CONVULSIONS	❑	❑	_____
DIABETES	❑	❑	_____
ENDOCRINE OR THYROID PROBLEMS	❑	❑	_____
FAINTING	❑	❑	_____
FREQUENT HEADACHES	❑	❑	_____
GLAUCOMA	❑	❑	_____
HEART PROBLEMS	❑	❑	_____
HEPATITIS	❑	❑	_____
HIGH BLOOD PRESSURE	❑	❑	_____
KIDNEY PROBLEMS	❑	❑	_____
LIVER PROBLEMS	❑	❑	_____
NEUROLOGICAL PROBLEMS	❑	❑	_____
PROLONGED BLEEDING	❑	❑	_____
REMOVAL OF TONSILS & ADENOIDS	❑	❑	_____
RHEUMATIC FEVER	❑	❑	_____
SINUS PROBLEMS	❑	❑	_____

DENTAL HISTORY

	YES	NO	(FOR OFFICE USE ONLY)
HAS THE PATIENT HAD A RECENT DENTAL CHECKUP? _____	❑	❑	DATE: _____
DOES THE PATIENT BITE LIP/FINGERNAILS? _____	❑	❑	_____
HAS THERE BEEN A BLOW OR INJURY TO FACE OR TEETH? _____	❑	❑	_____
HAVE TEETH BEEN KNOCKED OUT OF THE MOUTH AND REIMPLANTED? ____	❑	❑	_____
IS THERE A FINGER OR THUMB SUCKING HABIT? _____	❑	❑	_____
ARE THERE SPEECH PROBLEMS? _____	❑	❑	_____
HAS TREATMENT BEEN RECEIVED FOR THESE PROBLEMS? _____	❑	❑	_____
ARE THERE SWALLOWING PROBLEMS? _____	❑	❑	_____
IS THERE CLICKING OR PAIN WHEN OPENING THE JAW? _____	❑	❑	_____
HAS THE PATIENT EVER HAD JAW JOINT (TMJ) TREATMENT? _____	❑	❑	_____
IS THERE DIFFICULTY BREATHING THROUGH NOSE (MOUTH BREATHING)? __	❑	❑	_____
HAS THE PATIENT EVER HAD SURGERY TO REPAIR CLEFT LIP AND/OR PALATE? __	❑	❑	_____
DO THE PATIENT'S GUMS BLEED WHEN BRUSHING TEETH? _____	❑	❑	_____
DOES THE PATIENT USE DENTAL FLOSS? _____	❑	❑	_____
DOES THE PATIENT HAVE FREQUENT SORES IN THE MOUTH OR LIPS? _____	❑	❑	_____
DOES THE PATIENT PLAY A MUSICAL INSTRUMENT? IF SO, WHICH ONE? _____	❑	❑	_____
_____			

DIETARY HABITS

DOES THE PATIENT EAT BALANCED MEALS (MEAT, VEGETABLES, FRUIT, ETC.)? ____	❑	❑	_____
DOES THE PATIENT TAKE SUPPLEMENTAL VITAMINS? _____	❑	❑	_____
IS THERE A HIGH INTAKE OF SWEETS? _____	❑	❑	_____
DOES THE PATIENT CHEW GUM FREQUENTLY? _____	❑	❑	_____
DOES THE PATIENT CHEW ICE, EAT LEMONS OR LIMES? _____	❑	❑	_____

SLEEP HABITS

IS THE PATIENT A SOUND SLEEPER? _____	❑	❑	_____
DOES THE PATIENT SLEEP WITH MOUTH OPEN? _____	❑	❑	_____
DOES THE PATIENT SNORE? _____	❑	❑	_____
DOES THE PATIENT GRIND TEETH WHILE SLEEPING? _____	❑	❑	_____
HAS THE PATIENT BEEN TESTED FOR SLEEP APNEA? _____	❑	❑	_____
RESULTS? _____			

PLEASE DESCRIBE THE PATIENT'S INDIVIDUAL CHARACTER OR NATURE (FOR EXAMPLE: QUIET, OUTGOING, SELF-CONSCIOUS, RESPONSIBLE, LEADER, ONE OF THE GROUP, ETC.)

_____

_____

_____

_____

IF YOU HAVE ANY ADDITIONAL CONCERNS OR QUESTIONS YOU WISH THE DOCTOR TO BE AWARE OF, OR YOU WISH THE DOCTOR TO ANSWER, PLEASE DESCRIBE

_____

_____

_____

_____

_____

DATE SIGNATURE OF PERSON COMPLETING FORM

THANK YOU!