BRIAN SCOTT D.D.S., M.S.
orthodontics exclusively

Member American Association of Orthodontists

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Welcome To Our Office

PATIENT'S NAME _____
Last First Middle

NAME PATIENT GOES BY _____ BIRTHDATE _____ AGE _____
Mo. Day Yr.

SEX _____ HOME ADDRESS _____ HOME PHONE _____
Street City State Zip

EMAIL _____

PATIENT'S INTERESTS: SPORTS, HOBBIES, MUSIC, CHURCH _____

SS# _____ EMPLOYED BY _____ WORK PHONE _____

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

CLOSE FRIEND OR RELATIVE WHO IS A PATIENT IN THIS OFFICE _____

PERSON RESPONSIBLE FOR ACCOUNT (NAME) _____

IF YOU ARE COVERED BY DENTAL INSURANCE THAT PROVIDES FOR ORTHODONTIC TREATMENT, PLEASE COMPLETE THE FOLLOWING:

INSURED'S NAME _____ RELATIONSHIP TO PATIENT _____

INSURED'S SS# _____ INSURED'S DATE OF BIRTH _____

INSURED IS EMPLOYED WITH _____

INSURANCE COMPANY NAME _____

INSURANCE COMPANY ADDRESS _____

INSURANCE COMPANY PHONE # _____ INSURED'S ID # _____

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

SPOUSE

NAME _____
Last First Middle

ADDRESS _____
Street City State Zip

HOME PHONE _____ SS# _____ DATE OF BIRTH _____

EMPLOYED BY _____ WORK PHONE _____

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 _____		
DOES PATIENT USE TOBACCO	❑	❑
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

HAVE YOU HAD A RECENT DENTAL CHECKUP? ❑ ❑ DATE: _____

(FOR OFFICE USE ONLY)

DO YOU BITE LIP/FINGERNAILS? ❑ ❑ _____

HAS THERE BEEN A BLOW OR INJURY TO FACE OR TEETH? ❑ ❑ _____

HAVE TEETH BEEN KNOCKED OUT OF THE MOUTH AND REIMPLANTED? ❑ ❑ _____

ARE THERE SPEECH PROBLEMS? ❑ ❑ _____

HAS TREATMENT BEEN RECEIVED FOR THESE PROBLEMS? ❑ ❑ _____

ARE THERE SWALLOWING PROBLEMS? ❑ ❑ _____

IS THERE CLICKING OR PAIN WHEN OPENING THE JAW? ❑ ❑ _____

HAVE YOU EVER HAD JAW JOINT (TMJ) TREATMENT? ❑ ❑ _____

IS THERE DIFFICULTY BREATHING THROUGH NOSE (MOUTH BREATHING)? ❑ ❑ _____

HAVE YOU EVER HAD SURGERY TO REPAIR CLEFT LIP AND/OR PALATE? ❑ ❑ _____

DO YOUR GUMS BLEED WHEN BRUSHING TEETH? ❑ ❑ _____

DO YOU USE DENTAL FLOSS? ❑ ❑ _____

DO YOU HAVE FREQUENT SORES IN THE MOUTH OR LIPS? ❑ ❑ _____

DO YOU PLAY A MUSICAL INSTRUMENT? IF SO, WHICH ONE ❑ ❑ _____

_____

DIETARY HABITS

DO YOU EAT BALANCED MEALS (MEAT, VEGETABLES, FRUIT, ETC.)? ❑ ❑ _____

DO YOU TAKE SUPPLEMENTAL VITAMINS? ❑ ❑ _____

IS THERE A HIGH INTAKE OF SWEETS? ❑ ❑ _____

IS THERE A HIGH INTAKE OF CAFFEINE? ❑ ❑ _____

DO YOU CHEW GUM FREQUENTLY? ❑ ❑ _____

DO YOU CHEW ICE, EAT LEMONS OR LIMES? ❑ ❑ _____

SLEEP HABITS

ARE YOU A SOUND SLEEPER? ❑ ❑ _____

DO YOU SLEEP WITH YOUR MOUTH OPEN? ❑ ❑ _____

DO YOU SNORE? ❑ ❑ _____

DO YOU GRIND YOUR TEETH WHILE SLEEPING? ❑ ❑ _____

HAVE YOU EVER BEEN TESTED FOR SLEEP APNEA? ❑ ❑ _____

RESULTS? _____

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!

AUTHORIZATION

THIS OFFICE RESERVES THE RIGHT TO VERIFY THE CREDIT STATUS OF POTENTIAL 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 **DATE**

FACIAL AND FUNCTIONAL EXAM

SYMMETRY
❍ NORMAL
❍ ASYMMETRIC
❍ FACIAL MIDLINES OFF ❍ R ❍ L

LIP TONE
❍ NORMAL
❍ HYPER
❍ HYPO

UPPER LIP LENGTH
❍ NORMAL
❍ SHORT
❍ LONG

NASOLABIAL ANGLE
❍ NORMAL
❍ ACUTE
❍ OBTUSE

FACIAL MUSCLE BALANCE
❍ NORMAL
❍ HYPER
❍ HYPO

PROFILE
❍ ACCEPTABLE
❍ BIMAX
❍ MAXILLARY PROTRUSION
❍ SKELETAL ❍ DENTAL
❍ MAXILLARY RETRUSION
❍ SKELETAL ❍ DENTAL
❍ MANDIBULAR PROTRUSION
❍ SKELETAL ❍ DENTAL
❍ MANDIBULAR RETRUSION
❍ SKELETAL ❍ DENTAL

LOWER FACIAL HEIGHT
❍ NORMAL
❍ DEFICIENT
❍ EXCESSIVE

RESPIRATION
❍ NORMAL
❍ MOUTH BREATHING

SWALLOW
❍ NORMAL
❍ ABNORMAL
❍ TONGUE THRUST

SPEECH
❍ NORMAL
❍ ABNORMAL

HABITS
❍ NONE
❍ THUMB
❍ LIP
❍ TONGUE
❍ OTHER _____