Our Mission...

To Bring Out Your Best Smile

KUJAK ORTHODONTICS

PATIENT

Today's Date: _____

Name: _____
Last First Mi

I prefer to be called: _____

Birthdate: ___/___/___ Age: _____ SS#: _____

Home Address: _____

_____
City State Zip

Hobbies / Sports: _____

Previous / Present Dentist: _____
(Please Circle)

Last dental visit: _____
Month Year

Responsible Party

Person Responsible for Account: _____

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Hm #: (___) _____ Cell / Other #: (___) _____

Wk #: (___) _____ SS #: _____

E-mail Address: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

Where & when are best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

For Parents

Mother's Name: _____

Mother's Date of Birth: ___/___/___

Father's Name: _____

Father's Date of Birth: ___/___/___

OFFICE USE ONLY

I verbally reviewed the medical / dental information with the patient named herein.

Initials: _____ Date: _____

ORTHODONTIC INSURANCE

Primary

Dental Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #: (___) _____

Plan / Member / Subscriber #: _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's SS#: _____

Insured's Employer: _____

(All information required to file insurance)

Secondary

Dental Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #: (___) _____

Plan / Member / Subscriber #: _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's SS#: _____

Insured's Employer: _____

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. If applicable I hereby authorize payment of the group insurance benefits directly to this office. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company, if applicable.

_____
Signature Date

Continued on Back

DENTAL & MEDICAL HISTORY

Anything you would like to discuss with the Doctor in private? ❑ Yes ❑ No

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

_____

Have you ever been evaluated or had orthodontic treatment before? ❑ Yes ❑ No

Have there been any injuries to the face, mouth, teeth or chin? ❑ Yes ❑ No

Have adenoids or tonsils been removed? ❑ Yes ❑ No

Do you have any missing or extra permanent teeth? ❑ Yes ❑ No

Do you have any pain/tenderness in your jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Do you brush your teeth daily? ❑ Yes ❑ No

Do you floss your teeth daily? ❑ Yes ❑ No

Is your water fluoridated? ❑ Yes ❑ No

Are you taking fluoridated supplements? ❑ Yes ❑ No

Do your gums bleed? ❑ Yes ❑ No

Do you require antibiotics before dental work? ❑ Yes ❑ No

Please describe your current physical health: ❑ Good ❑ Fair ❑ Poor

Physician: ( ) _____

Phone #: _____ Date of Last Visit: _____

Are you currently under the care of a physician? ❑ Yes ❑ No

Have you ever taken Phen-Fen or Redux? ❑ Yes ❑ No

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

Have you had any metal rods, pins or implants? ❑ Yes ❑ No

Are you taking any prescription/over-the-counter drugs? ❑ Yes ❑ No

Has puberty begun? ❑ Yes ❑ No

FEMALES:

Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No ❑ Unsure Week #:_____

Are you nursing? ❑ Yes ❑ No

Has menstruation begun? ❑ Yes ❑ No

Please discuss any serious medical problems you have had:

_____

_____

Are your immunizations current? ❑ Yes ❑ No

Have you ever experienced the following medical problems?

Y N ADD/ADHD
Y N Autism
Y N Any Hospital Stays/Operations
Y N Ear Infections
Y N Handicaps/Disabilities
Y N Headaches
Y N Hypoglycemia
Y N Meningitis
Y N Migraine
Y N Pneumonia
Y N Polio
Y N Valley Fever

Do you have any of the following habits?

Y N Clenching/Grinding Teeth/Clicking
Y N Lip Sucking/Biting
Y N Mouth Breather
Y N Nail Biting
Y N Speech Problems
Y N Thumb/Finger Sucking ❑ Previous ❑ Current
Y N Tongue Thrust

Please list all drugs you are currently taking:

_____

Are you allergic to any of the following?

Y N Amoxicillin
Y N Aspirin
Y N Any Metal / Jewelry
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Latex
Y N Penicillin
Y N Plastic
Y N Sulfa
Y N Tetracycline

Other: _____

Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding / Hemophilia
Y N AIDS
Y N Alcohol / Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones / Joints / Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer / Chemotherapy
Y N Chicken Pox
Y N Colitis
Y N Congenital Heart Defect
Y N Convulsions / Epilepsy
Y N Diabetes
Y N Difficulty Breathing
Y N Drug Addiction
Y N Emphysema
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma / Eye Problems
Y N Hay Fever
Y N Hearing Impairment
Y N Heart Attack / Surgery
Y N Heart Murmur
Y N Hepatitis
Y N Herpes / Fever Blisters
Y N High Blood Pressure
Y N HIV
Y N Hives
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Lupus
Y N Measles
Y N Mitral Valve Prolapse
Y N Mononucleosis
Y N Pacemaker
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic / Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease / Traits
Y N Sinus Problems
Y N Skin Rash
Y N Stroke
Y N Thyroid Problem
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease

❑ Unknown HH _____

– FOR OFFICE USE ONLY –
MEDICAL HISTORY UPDATE

Has there been any change in your health status since your last visit? Y N
If Yes, please explain. _____

Has there been any change in your health status since your last visit? Y N
If Yes, please explain. _____

_____
Patient Signature Date

_____
Dentist Signature Date

_____
Patient Signature Date

_____
Dentist Signature Date

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent. 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 the office, use the services of one or more credit reporting services.

_____
Patient Signature (over 18) or Parent/Guardian Signature Date