BRADY
ORTHODONTICS PC

# PATIENT INFORMATION FORM

## PATIENT INFORMATION

Name _____ Nickname _____ M/F Age_____ Birthdate _____
Street Address _____
City _____ State _____ Zip _____ Phone_____
Name & Age of Siblings _____
Patient's School _____
If Patient is a college student, please provide a residence address _____
_____
Whom may we thank for referring you to our office? _____

## PARENT'S/GUARDIAN'S INFORMATION

Father's Name _____
Address _____City _____ State _____ Zip_____
Home Phone _____Work Phone _____ Cellphone_____
Mother's Name _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____Cellphone_____
E-mail Address_____

## RESPONSIBLE PARTY INFORMATION

Person responsible for account _____
Billing Address _____
Relationship to patient _____

## EMERGENCY CONTACT

Name _____ Relationship _____
Complete Address _____
Home Phone _____ Work Phone _____Cellphone_____

The office of Dr. Brady will be happy to process your orthodontic claims.
**To successfully process your claims, all of the following information is necessary.**
If you do not have all of the required information we suggest you contact your Human Resources Representative and they can help you with any missing information.

## DENTAL INSURANCE INFORMATION

**Primary Insured's Name** _____ **Insured's Date of Birth** _____
**Insurance Co.** _____ **Soc. Sec. No.** _____
**Insurance Co. Address** _____ **Phone** _____
**Insured's Employer** _____ **Group No.** _____

I hereby authorize release of any information relating to my insurance.
Signature: _____ Date _____
I hereby authorize payment of insurance benefits directly to the named Orthodontist.
Signature: _____ Date _____

Dual Insurance (if applicable)

**Secondary Insured's Name** _____ **Insured's Date of Birth** _____
**Insurance Co.** _____ **Soc. Sec. No.** _____
**Insurance Co. Address** _____ **Phone** _____
**Insured's Employer** _____ **Group No.** _____

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Patient's Name _____

## MEDICAL HISTORY

Physician_____ Phone _____

Complete address_____

General Health and Known Illnesses_____

_____

_____

Present Medications_____

Surgery (with Approximate Dates) _____

_____

Is there a possibility that you may be pregnant? Yes_____No____

Have you ever had an allergic reaction to medication? Yes____ No____

If Yes, please list medication(s)_____

Have you ever had an allergic reaction to foods, latex, any metals, especially **Nickel** or **Titanium,** or any other substance?

Yes_____ No_____ If Yes, please list your allergy(ies) to any of the above mentioned_____

_____

| Have you ever had any of the following: | Circle YES or NO | | | | |
|---|---|---|---|---|---|
| Bleeding History | No | Yes | High Blood Pressure | No | Yes |
| Cancer | No | Yes | Migraine Headaches | No | Yes |
| Diabetes | No | Yes | Stomach Ulcers | No | Yes |
| Hearing Loss | No | Yes | Hepatitis | No | Yes |
| Epilepsy | No | Yes | Kidney Problems | No | Yes |
| Liver Problems | No | Yes | AIDS or other Immune System disorder | No | Yes |

Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion arteriosclerosis, stroke) No Yes

Damaged heart valves (Mitral valve prolapse, artificial heart valve, heart murmur) or any other conditions which may require you to be premedicated. No Yes

**If yes, does your condition require you to be premedicated?**

_____

_____

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Patient's Name _____

## DENTAL HISTORY

Patient's Dentist _____Date of Last Visit _____

Complete address _____

1) Have you previously consulted an orthodontist? _____ Yes ____No___

If yes, when? _____

2) Have you consulted any other dental specialty? _____ Yes ____No___

If yes, when? _____

3) Is there a family history of congenitally missing teeth? Yes ____No___

Yourself _____ Relative(s) _____

4) Do your gums bleed when you brush your teeth? Yes ____No___

5) Is any part of your mouth sensitive to temperature? Yes ____No___
Is any part of your mouth sensitive to pressure? Yes ____No___

6) Have you ever sucked your thumb or finger(s)? Yes ____No___
If so, have you stopped this habit? Yes ____No___

7) Do you breathe predominantly through your mouth? Yes ____No___

8) Have you had your tonsils/adenoids removed? Yes ____No___

If Yes, when? _____

9) Do you clench or grind your teeth during the day? Yes ____No___

10) Have you been made aware of clenching or grinding your teeth during the night? Yes ___No____

11) Do you now have, or have you ever had, pain in your jaw joint or the sides of your face (in and about the ears)? Yes ____No____

12) Have you ever had clicking or popping in your jaw joint? Yes ____No___

If Yes, please explain _____

13) Have you ever experienced pain when you open wide? Yes ____No___

14) Have you had any injury to your jaw? Yes____No___

If Yes, please explain_____

15) Have you had any injury to your teeth? Yes____No____

If Yes, please explain_____