Welcome to Crow Canyon Orthodontics

ABOUT YOU

Today's Date: _______________

Name: _______________________________ I prefer to be called: ___________________ ☐ Male ☐ Female

Birthdate: ___/___/______ Age: _____ Social Security # ________________ Email: _______________________

Home Address: _____________________________ City: __________________ State: ______ Zip: ______________

Home Phone #_____________ Cell Phone #_____________ Work Phone# _____________

☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Employer: ________________________ How long there? __________ Occupation: ________________________

Other family members seen by us: ____

Who may we thank for referring you? ____

In case of an emergency please contact:

Name: ____________________________ Relation: ____________________ Phone # _________________________

SPOUSE INFORMATION

Name: ______________________________ Birthdate: ___/___/______ Social Security #____________________

Employer: _______________________ How long? _________________ Occupation: ________________________

INSURANCE INFORMATION

Primary

Subscriber's Name: _____________________ Birthdate: ___/___/______ Subscriber's SSN:___________________

Subscriber's Address: _____________________________ City: __________________ State: ______ Zip: __________

Relationship to Patient: ____

Insurance Co. Name: ___________________________ Phone #_________________ Group #_________________

Insurance Co. Address: ___________________________ City: __________________ State: ______ Zip: __________

Subscriber's Employer: ____

Secondary

Subscriber's Name: _____________________ Birthdate:___/___/______ Subscriber's SSN: ___________________

Subscriber's Address: _____________________________ City: __________________ State: ______ Zip: __________

Relationship to Patient: ____

Insurance Co. Name: ___________________________ Phone #_________________ Group # __________________

Insurance Co. Address: ___________________________ City: __________________ State: ______ Zip: __________

Subscriber's Employer: ____

crowcanyonorthodontics

DENTAL AND MEDICAL HISTORY

What Treatment Goals would you like to accomplish? ____

Have you ever been evaluated by an Orthodontist? ☐Yes ☐No

Have you ever experienced any TMJ Pain? ☐Yes ☐No

Have you been informed of extra or missing teeth? ☐Yes ☐No

Have you had injury to your mouth, chin, or teeth? ☐Yes ☐No

Your current dental health is ☐Good ☐Fair ☐Poor

Are you a mouth breather? ☐Yes ☐No

Are you currently under the care of a Physician? ☐Yes ☐No If yes, please explain:__________________________

Physician's Name: ______________________ Phone #__________________ Date of Last Visit:______________

Are you currently taking any medication? Please list ____

Are you allergic to ☐Latex ☐Plastics/Metals ☐Aspirin ☐Penicillin ☐Other:______________________________

For women: Are you pregnant? ☐Yes ☐No If yes, weeks: __________ Are you nursing? ____________________

Have you ever had any of the following medical conditions?

Y N	Abnormal Bleeding	Y N	Emphysema	Y N	Mitral Valve Prolapse
Y N	Alcohol/ Drug Abuse	Y N	Epilepsy/Fainting/Seizures	Y N	Psychiatric Problems
Y N	Anemia	Y N	Fever Blisters/ Herpes	Y N	Rheumatic/ Scarlet Fever
Y N	Arthritis	Y N	Glaucoma	Y N	Shingles
Y N	Artificial Bones/Joints/Val	Y N	Headaches	Y N	Sickle Cell Disease
Y N	Asthma	Y N	Heart Condition/ Attack	Y N	Sinus Problems
Y N	Blood Transfusion	Y N	Hepatitis	Y N	Stroke
Y N	Cancer/Chemotherapy	Y N	High/Low Blood Pressure	Y N	Thyroid Problems
Y N	Congenital Heart Defect	Y N	HIV+/AIDS	Y N	Tuberculosis (TB)
Y N	Diabetes	Y N	Hospitalizations	Y N	Ulcers
Y N	Difficulty Breathing	Y N	Kidney Problems	Y N	Venereal Disease

Please list any serious medical condition(s) and/or hospitalizations that you have experienced: ______________
____

Have you ever taken Phen-Fen? Also known as Redux or Pondimin. ☐Yes ☐No

Have you ever taken Fosamax or any other bisphosphonate? ☐Yes ☐No

I affirm that the information I have given is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health and it is my responsibility to inform this office of any changes in medical status.

Signature____ Date: ____________________________