Welcome to our office

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can.

Patient Information

Name: ______________________ Nickname: ____________ Gender: ______ Age: _____ DOB: __________

E-mail ____

Home address: ______________________________________ Phone: ______________

Occupation: ______________ Employer: ______________________ Bus. Ph: ______________

Marital Status: _____ Spouse's name: ____________________ Emlpoyer: ____________ Bus. Ph: ____________

Children: ____

Whom may we thank for referring you to our office? ______________________________

Account Information

A consumer credit report may be ordered in connection with payment arrangements or subsequently with update, renewal or extension of credit. Upon your request, you will be informed whether or not a consumer report was ordered, and if it was, you will be given the name and address of the consumer reporting agency that furnished that information.

Person responsible for acount: ______________________________ Relation: ______________

If other than patient or parent previously indicated:

Home address: ______________________ City: __________ Zip: ______ Phone: __________

Occupation: ______________ Employer: ______________________ Bus. Phone: ______________

Length of employment ______________

Insurance Information

A dental insurance policy is a contract between the insured and the insurance company. Our professional services are rendered and charged directly to the patient's account and the person responsible for the account is responsible for all fees incurred. For your convenience, we will gladly assist you in submitting insurance claims pertaining to any charge for care in our office.

Insured ______________________	Insured ______________________
ID# ______________ DOB ________	ID# ______________ DOB ________
Employer: ______________________	Employer: ______________________
Address: ______________________	Address: ______________________
Insurance Co. ______________________	Insurance Co. ______________________
Insurance Address: ______________________	Insurance Address: ______________________
Phone # ______________ Group # ________	Phone # ______________ Group # ________

Name: ______________________________ Nickname: ______________ Gender: ______ Age: ____

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your orthodontic care. All information will be kept completely confidential.

Medical History

Physicians Name: ______________________________ Phone: ______________ Last visit: ____________

	No	Yes	
Are you in good health?	❑	❑	Date of last Physical exam: ____________
Are you currently under the care of a physician?	❑	❑	For what condition? ____________
Are you currently taking any medicines or drugs?	❑	❑	List ____________
Are you allergic to any medications?	❑	❑	List ____________
Have you ever been treated for mental or nervous disorders?	❑	❑	List ____________
Have you ever had any serious illness, operation or been hospitalized?	❑	❑	List ____________

Please check if you have had any of the following conditions:

❑ Heart Murmur	❑ Hepatitis	❑ Asthma	❑ Epilepsy
❑ Artificial Heart Valves	❑ Liver Disease	❑ Sinus trouble	❑ Fainting/Dizzy Spells
❑ Rheumatic Fever	❑ Thyroid Disorder	❑ Tuberculosis	❑ AIDS or HIV infection
❑ Other Heart Disorder	❑ Diabetes	❑ Arthritis	❑ Herpes (Fever Blisters)
❑ Artificial Joint	❑ Kidney Disease	❑ Growth or Bone Disorder	❑ Other Venereal Disease
❑ High Blood Pressure	❑ Anemia	❑ Other: ____________	❑ Other: ____________

Height: ____________ Weight: ____________ Do you wear contact lenses? ❑ No ❑ Yes

Female: Are you pregnant? ❑ No ❑ Yes How many months? ______ Do you take birth control pills? ❑ No ❑ Yes

Is there any other medical information we should know about? ______________________________

Dental History

Dentist's name: ______________________________ Phone: ______________ Last visit: ________

	No	Yes	Please explain
Have you ever had dental injuries?	❑	❑	____________
Do you play any musical instruments?	❑	❑	____________
Have you had any previous orthodontic treatment?	❑	❑	____________
Have you had any gum problems or treatment?	❑	❑	____________
Have you had any complications associated with dental treatment?	❑	❑	____________

Is there a history of: (Please mark those which apply)

❑ Thumb/Finger sucking	❑ Clenching your teeth	❑ Jaw joint or muscle soreness
❑ Speech Problems	❑ Grinding your teeth	❑ Jaw joint popping or clicking
❑ Mouth Breathing	❑ Jaw joint locking	❑ TMJ Therapy

What is your primary orthodontic concern? ______________________________

Is there any other dental information we should know about? ______________________________

____

My signature confirms I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA)

____

Patient/Parent signature **Date**

Thank you for your time and patience in supplying this important information.

Dr. B. Robert Cohanim 600 Broadway, Suite 520 Seattle, Washington 98122 206-32-Brace (206)-322-7223
fax 206-322-7263 e-mail:info@smile-works.com