Orthodontic Associates of Collegeville, P.C.
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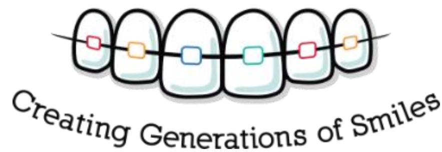
Orthodontics for Children & Adults



Creating Generations of Smiles

PATIENT BIOGRAPHICAL INFORMATION

Name: ____Date of Birth_____/_____/_________

I Prefer to be Called: _________________________________Gender: ☐ Male ☐ Female ☐ Non-binary

Address: ____City: _________________________

State: _______Zip: ______________ Email: ____

Cell Phone: _______________________________ Other Phone: ___________________________________

Other Family Members in our Practice: ____

Who May we Thank for Referring You? ____

FINANCIAL PARTY AND INSURANCE INFORMATION

☐ **Check if the patient is also the person who will be financially responsible for treatment**

Primary Responsible Party

Name: ____Relation to patient: _________________

Address: ____City: _________________________

State: _______Zip: _______________ Email: ____

Cell Phone: _______________________________ Other Phone: ___________________________________

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated

Do you have insurance that covers Orthodontic Treatment? ☐ Yes ☐ No

Primary Insurance

Insurance Co. Name: _______________________________________ Phone: ________________________

Subscriber Name: ____DOB: _____/_____/___________

Insurance ID#___________________________________ Group #____________________________________

Subscriber Employer: ____

Secondary Insurance

Insurance Co. Name: _______________________________________ Phone: ________________________

Subscriber Name: ____DOB: _____/_____/___________

Insurance ID#___________________________________ Group #____________________________________

Subscriber Employer: ____

☐ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I understand I am financially responsible for any balance not paid by my insurance company. ***Please put your initials in the box***. Please provide this office with any **Primary/Secondary** Insurance cards.

DENTAL HISTORY

Name of **GENERAL DENTIST**: ____

Date of Last Dentist Visit: _____/_____/_________ Check-up Frequency: ___________________________

Has the patient had an orthodontic consult or previous treatment? ☐ Yes ☐ No

If yes, when? ____

What is the patient's main orthodontic concern? ____

Please select YES if the patient has had any of the conditions listed below either now or in the past.

Speech problems/therapy	☐ Yes ☐ No	Brush teeth daily?	☐ Yes ☐ No
Grind or clench teeth?	☐ Yes ☐ No	Floss teeth daily?	☐ Yes ☐ No
Oral habits (thumb/finger) or lip/nailbiting	☐ Yes ☐ No	Flouride treatments?	☐ Yes ☐ No
Injury to face, jaw, teeth or mouth?	☐ Yes ☐ No	Mouth breathing?	☐ Yes ☐ No
Discomfort from teeth or gums?	☐ Yes ☐ No	Snores during sleep?	☐ Yes ☐ No
Pain, tenderness, or noise in jaw?	☐ Yes ☐ No	Requires premedication?	☐ Yes ☐ No
Frequent headaches?	☐ Yes ☐ No	Missing or extra teeth?	☐ Yes ☐ No
Neck/ shoulder pain?	☐ Yes ☐ No	Apprehensive about dental care?	☐ Yes ☐ No
Frequent sore throats?	☐ Yes ☐ No	Frequently chews gum?	☐ Yes ☐ No
If any of the above dental questions were answered 'Yes', please explain:			

MEDICAL HISTORY

Name of Physician: ____ Date of Last Physical: _____/_____/________
Physician Address: ____City: ______________________________
State: ________ Zip: ___________________ Physician Phone: ____

General physical health of patient: ☐ Excellent ☐ Good ☐ Fair ☐Poor

Is the patient currently taking any medications? ☐ Yes ☐ No
If yes, please list: ____

Does the patient have any drug allergies/sensitivities? ☐ Yes ☐ No
If yes, please list: ____

Does the patient have any metal, latex or plastic allergies/sensitivities? ☐ Yes ☐ No
If yes, please list: ____

Has patient ever been hospitalized? ☐ Yes ☐ No
If yes, please explain: ____

Please select YES if the patient has had any of the conditions listed below either now or in the past.

Rheumatic Fever	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Tuberculosis/Lung Disease	☐ Yes ☐ No	Family History of Cancer	☐ Yes ☐ No
Pneumonia	☐ Yes ☐ No	Received Radiation Treatment	☐ Yes ☐ No
Liver Disease	☐ Yes ☐ No	Growth Problems	☐ Yes ☐ No
Kidney Disease	☐ Yes ☐ No	Endocrine Problems	☐ Yes ☐ No
Heart Attack/Stroke	☐ Yes ☐ No	Hormone Therapy	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	ADD/ADHD	☐ Yes ☐ No
Congenital Heart Defect	☐ Yes ☐ No	Nervous Disorder	☐ Yes ☐ No

Heart Murmur	☐ Yes ☐ No	Bone Disorder/Bone Loss	☐ Yes ☐ No
Bleeding Disorder/Transfusion	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Hypertension/High Blood Pressure	☐ Yes ☐ No	Seizures/Epilepsy	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Handicaps/Disabilities	☐ Yes ☐ No
HIV/AIDS	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No
Tonsils/Adenoids Removed	☐ Yes ☐ No	Treated for Emotional Problems	☐ Yes ☐ No

If any of the above medical questions were answered 'Yes', please explain:

FOR PATIENTS UNDER 18, please answer the following questions:

Mother's Name: ____
Father's Name: ____
Guardian's Name: ____
Name and Ages of any Siblings: ____
____
Patient's Height: ______________________ Patient's Weight: _____________________
School: ____ Grade: ________________
List sports, hobbies or musical instruments played____________________________________

Has patient begun puberty?	☐ Yes ☐ No
If patient is a girl, has menstruation begun?	☐ Yes ☐ No
If patient is a boy, has their voice changed or have facial hair?	☐ Yes ☐ No
Has the patient grown in the past year or has shoe size changed recently?	☐ Yes ☐ No
Does patient have an interest in orthodontic treatment?	☐ Yes ☐ No
Has either biological parent ever had orthodontic treatment?	☐ Yes ☐ No

I understand the above information was completed to the best of my knowledge and understand it is my responsibility to inform this office of any further changes to the information I have provided.

Responsible Party Signature ______________________________

Today's Date______________________________

for office use only
Doctor's Comments: ____
____
____
____

Doctor Signature: ___________________________ Date: _______________