



ORTHODONTICS

(860) 633-8321 risingerortho.com

Thank you for filling out this important information form. Providing you and your family with the best care possible is our top priority. If you have any questions or need assistance, just ask. We're happy to help!

Patient Information

NAME, DATE OF BIRTH, AGE, M, F, PREFERRED NAME, GRADE, HOME PHONE, ADDRESS, CELL PHONE, CITY, STATE, ZIP, EMAIL, SCHOOL, INTERESTS

IF PATIENT IS A MINOR:

NAME/RELATIONSHIP OF PERSON ACCOMPANYING PATIENT TO TODAY'S APPOINTMENT, PATIENT LIVES WITH WHOM/RELATIONSHIP, WHO HAS LEGAL CUSTODY OF PATIENT?, NAME OF SIBLINGS & AGES

Responsible Party

NAME, MARITAL STATUS, CELL PHONE, WORK PHONE, EMAIL, HOME PHONE, BIRTHDATE, SOCIAL SECURITY #, ADDRESS, CITY, STATE, ZIP, EMPLOYER, OCCUPATION, SPOUSE'S NAME/ OTHER PARENT, RELATIONSHIP TO PATIENT, SOCIAL SECURITY #, BIRTHDATE, WORK PHONE, CELL PHONE

Primary Insurance Information

CHECK HERE IF NO ORTHODONTIC COVERAGE WILL BE APPLIED

EMPLOYER, POLICY ID NUMBER, INSURANCE COMPANY, GROUP NUMBER, INSURANCE COMPANY ADDRESS, INSURANCE PHONE NUMBER, SUBSCRIBER, DOB, RELATIONSHIP TO PATIENT, IN CASE OF EMERGENCY, PLEASE CONTACT, PHONE

How did you choose Risinger Orthodontics? CHECK ALL THAT APPLY

GOOGLE, BING/YAHOO, FACEBOOK, FRIEND/FAMILY, INSTAGRAM, NEXTDOOR, SCHOOL SPONSORSHIP, DENTIST/DOCTOR, PRINT ARTICLE OR FLYER, MAGAZINE AD, DIRECT MAIL, OTHER, RADIO, BILLBOARD, EVENT

PLEASE READ: We are passionate about our mission to give everyone a beautiful smile. Please help us to help you and your child by letting us know of any delayed development, social disabilities, ADD or ADHD, Bipolar, Autism, etc.

Medical History

PHYSICIAN _____ PHONE _____ DATE OF LAST EXAM _____

<p>1. ARE YOU UNDER MEDICAL TREATMENT NOW? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>2. HAVE YOU BEEN HOSPITALIZED FOR ANY SURGICAL OPERATIONS OR SERIOUS ILLNESS IN THE PAST FIVE YEARS? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>3. ARE YOU TAKING MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>IF YES, WHAT MEDICATION(S) ARE YOU TAKING? _____</p> <p>4. DO YOU USE TOBACCO? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>5. ARE YOU AWARE OF BEING ALLERGIC TO ANY MEDICATIONS OR SUBSTANCE, INCLUDING METALS? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>IF YES, WHAT? _____</p> <p>6. FEMALES ONLY: <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>ARE YOU PREGNANT, OR THINK YOU MAY BE? <input type="checkbox"/> Y <input type="checkbox"/> N</p>	<p>7. EVER TAKEN BISPHOSPHONATES (EX: FOSAMAX) FOR OSTEOPOROSIS? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>IF YES, SPECIFY _____</p> <p>8. HAS THE PATIENT REACHED PUBERTY? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>9. IS THE PATIENT ALLERGIC TO LATEX? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>10. PLEASE CHECK ALL THAT APPLY:</p> <table border="0"> <tr> <td style="width: 50%; vertical-align: top;"> <p>HAY FEVER/ALLERGIES <input type="checkbox"/></p> <p>COLD SORES <input type="checkbox"/></p> <p>MIGRAINES <input type="checkbox"/></p> <p>DIABETES/GLAUCOMA RHEUMATIC <input type="checkbox"/></p> <p>FEVER <input type="checkbox"/></p> <p>AIDS OR HIV INFECTION CARDIAC <input type="checkbox"/></p> <p>PACEMAKER <input type="checkbox"/></p> <p>ASTHMA (INHALER) <input type="checkbox"/></p> <p>FAINTING/SEIZURES <input type="checkbox"/></p> <p>THYROID PROBLEM <input type="checkbox"/></p> <p>HIGH/LOW BLOOD PRESSURE <input type="checkbox"/></p> <p>HEART TROUBLE <input type="checkbox"/></p> <p>EPILEPSY/CONVULSIONS REMOVAL <input type="checkbox"/></p> <p>OF ADENOID/TONSILS <input type="checkbox"/></p> </td> <td style="width: 50%; vertical-align: top;"> <p>LEUKEMIA <input type="checkbox"/></p> <p>KIDNEY/LIVER DISEASE ANEMIA <input type="checkbox"/></p> <p>CANCER <input type="checkbox"/></p> <p>JOINT REPLACEMENT/IMPLANT <input type="checkbox"/></p> <p>HEPATITIS/JAUNDICE STOMACH <input type="checkbox"/></p> <p>TROUBLES/ULCERS SINUS <input type="checkbox"/></p> <p>PROBLEMS <input type="checkbox"/></p> <p>STROKE <input type="checkbox"/></p> <p>RADIATION THERAPY <input type="checkbox"/></p> <p>RESPIRATORY PROBLEMS BONE <input type="checkbox"/></p> <p>DISORDER OSTEOPENIA/ OSTEOPOROSIS <input type="checkbox"/></p> </td> </tr> </table>	<p>HAY FEVER/ALLERGIES <input type="checkbox"/></p> <p>COLD SORES <input type="checkbox"/></p> <p>MIGRAINES <input type="checkbox"/></p> <p>DIABETES/GLAUCOMA RHEUMATIC <input type="checkbox"/></p> <p>FEVER <input type="checkbox"/></p> <p>AIDS OR HIV INFECTION CARDIAC <input type="checkbox"/></p> <p>PACEMAKER <input type="checkbox"/></p> <p>ASTHMA (INHALER) <input type="checkbox"/></p> <p>FAINTING/SEIZURES <input type="checkbox"/></p> <p>THYROID PROBLEM <input type="checkbox"/></p> <p>HIGH/LOW BLOOD PRESSURE <input type="checkbox"/></p> <p>HEART TROUBLE <input type="checkbox"/></p> <p>EPILEPSY/CONVULSIONS REMOVAL <input type="checkbox"/></p> <p>OF ADENOID/TONSILS <input type="checkbox"/></p>	<p>LEUKEMIA <input type="checkbox"/></p> <p>KIDNEY/LIVER DISEASE ANEMIA <input type="checkbox"/></p> <p>CANCER <input type="checkbox"/></p> <p>JOINT REPLACEMENT/IMPLANT <input type="checkbox"/></p> <p>HEPATITIS/JAUNDICE STOMACH <input type="checkbox"/></p> <p>TROUBLES/ULCERS SINUS <input type="checkbox"/></p> <p>PROBLEMS <input type="checkbox"/></p> <p>STROKE <input type="checkbox"/></p> <p>RADIATION THERAPY <input type="checkbox"/></p> <p>RESPIRATORY PROBLEMS BONE <input type="checkbox"/></p> <p>DISORDER OSTEOPENIA/ OSTEOPOROSIS <input type="checkbox"/></p>
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Dental History

DENTIST _____

DATE OF LAST CLEANING _____

<p>1. ARE YOU ANXIOUS OR NERVOUS ABOUT DENTAL TREATMENT? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>2. DO YOU REQUIRE PREMEDICATION FOR DENTAL TREATMENT? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>3. DO YOU FEEL PAIN IN ANY OF YOUR TEETH? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>4. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>5. HAVE YOU HAD ANY HEAD, NECK, OR JAW INJURIES? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>IF YES, PLEASE DESCRIBE: _____</p> <p>6. DO YOU HAVE ANY ONGOING PROBLEMS IN YOUR JAW WITH:</p> <table border="0"> <tr> <td style="width: 50%; vertical-align: top;"> <p>A. CHRONIC CLICKING OR POPPING? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>B. PAIN? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>C. DIFFICULTY OPENING OR CLOSING? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>D. DIFFICULTY IN CHEWING? <input type="checkbox"/> Y <input type="checkbox"/> N</p> </td> <td style="width: 50%; vertical-align: top;"> <p>7. DO YOU CLENCH OR GRIND YOUR TEETH? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>8. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>9. HAVE YOU EVER HAD SPEECH THERAPY? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>IF YES, PLEASE DESCRIBE: _____</p> </td> </tr> </table>	<p>A. CHRONIC CLICKING OR POPPING? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>B. PAIN? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>C. DIFFICULTY OPENING OR CLOSING? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>D. DIFFICULTY IN CHEWING? <input type="checkbox"/> Y <input type="checkbox"/> N</p>	<p>7. DO YOU CLENCH OR GRIND YOUR TEETH? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>8. 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Authorization and Release

TO THE BEST OF MY KNOWLEDGE THE ABOVE QUESTIONS HAVE BEEN ANSWERED ACCURATELY. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES TO THE PATIENT'S MEDICAL STATUS. I GIVE RISINGER ORTHODONTICS PERMISSION TO PERFORM THE NECESSARY DENTAL SERVICES THAT THE PATIENT MAY NEED.

DATE _____

PRINT NAME _____

RELATIONSHIP TO PATIENT _____

SIGNATURE OF PATIENT (OR PARENT IF MINOR) _____

16. HAS THE PATIENT HAD AN ORTHODONTIC EVALUATION OR TREATMENT BEFORE? IF SO, WHEN AND BY WHOM? _____

17. DO YOU HAVE A PREFERENCE OF BRACES OR INVISALIGN? _____

DOCTOR SIGNATURE _____

DOCTOR COMMENTS _____