Risinger
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
IF YES, WHO? _____

☐ INSTAGRAM
☐ NEXTDOOR
☐ SCHOOL SPONSORSHIP
☐ DENTIST/DOCTOR
IF YES, WHAT IS THEIR NAME? _____

☐ PRINT ARTICLE OR FLYER
☐ MAGAZINE AD
☐ DIRECT MAIL
☐ OTHER
IF OTHER, PLEASE DESCRIBE: _____

☐ 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 _____

	Y	N
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. HAVE YOU BEEN HOSPITALIZED FOR ANY SURGICAL OPERATIONS OR SERIOUS ILLNESS IN THE PAST FIVE YEARS?	☐	☐
3. ARE YOU TAKING MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE? IF YES, WHAT MEDICATION(S) ARE YOU TAKING?	☐	☐
4. DO YOU USE TOBACCO?	☐	☐
5. ARE YOU AWARE OF BEING ALLERGIC TO ANY MEDICATIONS OR SUBSTANCE, INCLUDING METALS? IF YES, WHAT?	☐	☐
6. FEMALES ONLY: ARE YOU PREGNANT, OR THINK YOU MAY BE?	☐	☐
7. EVER TAKEN BISPHOSPHONATES (EX: FOSAMAX) FOR OSTEOPOROSIS? IF YES, SPECIFY	☐	☐
8. HAS THE PATIENT REACHED PUBERTY?	☐	☐
9. IS THE PATIENT ALLERGIC TO LATEX?	☐	☐

10. PLEASE CHECK ALL THAT APPLY:

HAY FEVER/ALLERGIES	☐	LEUKEMIA	☐
COLD SORES	☐	KIDNEY/LIVER DISEASE ANEMIA	☐
MIGRAINES	☐	CANCER	☐
DIABETES/GLAUCOMA RHEUMATIC	☐	JOINT REPLACEMENT/IMPLANT	☐
FEVER	☐	HEPATITIS/JAUNDICE STOMACH	☐
AIDS OR HIV INFECTION CARDIAC	☐	TROUBLES/ULCERS SINUS	☐
PACEMAKER	☐	PROBLEMS	☐
ASTHMA (INHALER)	☐	STROKE	☐
FAINTING/SEIZURES	☐	RADIATION THERAPY	☐
THYROID PROBLEM	☐	RESPIRATORY PROBLEMS BONE	☐
HIGH/LOW BLOOD PRESSURE	☐	DISORDER OSTEOPENIA/	☐
HEART TROUBLE	☐	OSTEOPOROSIS	☐
EPILEPSY/CONVULSIONS REMOVAL	☐		☐
OF ADENOIDS/TONSILS	☐		

Dental History

DENTIST _____

DATE OF LAST CLEANING _____

	Y	N
1. ARE YOU ANXIOUS OR NERVOUS ABOUT DENTAL TREATMENT?	☐	☐
2. DO YOU REQUIRE PREMEDICATION FOR DENTAL TREATMENT?	☐	☐
3. DO YOU FEEL PAIN IN ANY OF YOUR TEETH?	☐	☐
4. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	☐	☐
5. HAVE YOU HAD ANY HEAD, NECK, OR JAW INJURIES? IF YES, PLEASE DESCRIBE:	☐	☐
6. DO YOU HAVE ANY ONGOING PROBLEMS IN YOUR JAW WITH:		
A. CHRONIC CLICKING OR POPPING?	☐	☐
B. PAIN?	☐	☐
C. DIFFICULTY OPENING OR CLOSING?	☐	☐
D. DIFFICULTY IN CHEWING?	☐	☐
7. DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐
8. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	☐	☐
9. HAVE YOU EVER HAD SPEECH THERAPY? IF YES, PLEASE DESCRIBE:	☐	☐

	Y	N
11. IS THERE ANY OUTSTANDING DENTAL TREATMENT TO BE COMPLETED? IF YES, PLEASE DESCRIBE:	☐	☐
12. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING AND FLOSSING YOUR TEETH?	☐	☐
13. DO YOU HAVE ANY OF THE FOLLOWING ORAL HABITS:		
A. NAIL BITING?	☐	☐
B. THUMB SUCKING?	☐	☐
C. TONGUE THRUST WHILE SWALLOWING?	☐	☐
D. MOUTH BREATHING?	☐	☐

14. HOW MANY TIMES A DAY DO YOU BRUSH? _____

15. PLEASE CHECK THE BOXES BELOW WHICH DESCRIBE THE PROBLEM(S) FOR WHICH YOU ARE SEEKING TREATMENT:

CROWDING	☐	MISSING TEETH	☐
EXTRA SPACE	☐	EXTRA PERMANENT TEETH	☐
TEETH STICK OUT TOO FAR	☐	TEETH ERUPTING IN THE WRONG POSITION	☐
TMJ PROBLEMS	☐		
POOR BITE RELATIONSHIP	☐	OTHER: _____	

	Y	N
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? _____

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) _____

DOCTOR SIGNATURE _____

DOCTOR COMMENTS _____