LOZMAN ORTHODONTICS

Specialists in Orthodontics for Children & Adults

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The benefits of a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset.
Please fill out the form completely.

1 ABOUT YOU

Today's Date: _____

E-mail Address: _____

Name: _____
Last First MI MR MRS MS DR

I prefer to be called: _____ ■ Male ■ Female

Birthdate: __/__/__ Age: _____ SS#: _____

Home Address: _____
APT/CONDO #:

_____
CITY STATE ZIP

■ Single ■ Married ■ Divorced ■ Widowed ■ Separated

Hm #: (_____) _____ Cell #: _____

Wk #: (_____) _____ Ext: ___ DL #: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

General Dentist: _____

Last Visit Date: _____

2 SPOUSE INFORMATION

Name: _____

Employer: _____

Wk#: (_____) _____ Ext: ____ SS#: _____

Birthdate: ____/____/____

Person Responsible for Account: _____

Wk#: (_____) _____ Ext: ____ Hm #: _____

Billing Address: _____

Relation: _____ SS #: _____

Employer: _____ DL #: _____

3 ORTHODONTIC INSURANCE

Primary

Orthodontic Coverage: ■ Yes ■ No Dental Coverage: ■ Yes ■ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone#: (_____) _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____ **Relation:** _____

Insured's Birthdate: __/__/__ **Insured's** ID #: _____

Insured's Employer: _____

Secondary

Orthodontic Coverage: ■ Yes ■ No Dental Coverage: ■ Yes ■ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone#: (_____) _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____ **Relation:** _____

Insured's Birthdate: __/__/__ **Insured's** ID #: _____

Insured's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

Name: _____ Relation: _____

Wk #: (_____) _____ Hm #: _____

4 MEDICAL HISTORY

Do you have a personal physician? ■ Yes ■ No

Physicians Name: _____

Address: _____

Phone #: (_____) _____ Date of last visit: _____

CONTINUED ON BACK

4 MEDICAL HISTORY *continued*

Your current physical health is: ■ Good ■ Fair ■ Poor

Are you currently under the care of a physician? ■ Yes ■ No

Please explain: _____

Are you taking any prescription / over-the-counter drugs? ■ Yes ■ No

Please list each one: _____

_____

Please list all allergies:

_____

_____

Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding	Y N Hemophilia
Y N Anemia	Y N Hepatitis
Y N Artificial Bones / Joints / Valves	Y N High / Low Blood Pressure
Y N Asthma / Arthritis	Y N HIV + / AIDS
Y N Blood Transfusion	Y N Hospitilized for Any Reason
Y N Cancer / Chemotherapy	Y N Kidney Problems
Y N Congenital Heart Defect	Y N Mitral Valve Prolapse
Y N Diabetes	Y N Psychiatric Problems
Y N Difficulty Breathing	Y N Radiation Treatment
Y N Drug/Alchohol Abuse	Y N Rheumatic / Scarlet Fever
Y N Emphysema	Y N Severe/Frequent Headaches
Y N Epilepsy / Seizures / Fainting	Y N Shingles
Y N Fever Blisters/Herpes	Y N Sickle Cell Disease/Traits
Y N Glaucoma	Y N Sinus Problems
Y N Heart Attack / Stroke	Y N Tuberculosis (TB)
Y N Heart Murmur	Y N Ulcers / Colitis
Y N Heart Surgery/Pacemaker	Y N Venereal Disease

WOMEN: Are you pregnant: Y N

You must inform us if you become pregnant _____ Initials

5 DENTAL HISTORY

What are the main concerns that you would like orthodontic treatment to accomplish? _____

_____

_____

Have you ever had or been evaluated for orthodontic treatment? Y N

Have you ever had a serious / difficult problem associated with any previous dental treatment? Y N

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? Y N

Your current dental health is: ■ Good ■ Fair ■ Poor

Do you like your smile? Y N Gums ever bleed? Y N

Have you ever had an injury to your: Mouth Teeth Chin

Do you have any speech problems? _____

Do you generally breathe through your mouth? Y N

If yes, please circle: While Awake? While Asleep?

Do you have any missing or extra permanent teeth? Y N

Have you ever taken Fosamax, or any other bisphosphonate? Y N

Have you ever taken Phen-Fen? Y N

Do you smoke or use tobacco in any form? Y N

I

I understand that the information I have given is correct to the best of my knowledge. I also undertand that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need for diagnosis and/or treatment.

_____

Signature **Date**

Thank you for filling out this form completely.

We permit this office to verify the credit status of patients and / or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

_____

Signature Date

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office.

_____

Signature Date

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY**

I verbally reviewed the medical / dental information above with the patient named herein. Initials:_____ Date:_____

Doctor's Comments: _____

_____

_____

_____