Date: ______________________________

PATIENT

First and last name: ____ Preferred greeting: ____________________________

Title: □ Mr. □ Mrs. □ Ms. □ Miss □ Dr. □ Other: ___________

Date of birth: ____________________________ Age: ___________ Sex: □ Male □ Female

Marital status: □ Single □ Married □ Separated □ Divorced □ Widowed

Home address: ____

Home phone: _____________________________________ Patient's cell phone: _____________________________________

Occupation: ______________________________________ Email address: ____

NEAREST RELATIVE

Name of spouse or nearest relative: ____

Title: □ Mr. □ Mrs. □ Ms. □ Miss □ Dr. □ Other: __________ Relationship to patient: __________________________

Home phone *(if different)*: ___________________________ Cell phone*:* ____

Address *(if different)*: ____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? ____

Home phone *(if different)*: _____________________________________ Cell phone: ________________________________

Address *(if different)*: ____

DENTIST

Patient's dentist: ____ City, State: ____________________________________

Last seen: _______________ Reason: ____________________________ Next appointment: ____________________________

GENERAL INFORMATION

Who referred you to our office? ____

What concerns you about your teeth? ____

Any previous orthodontic treatment and/or consultations? ____

Have any other family members been treated at our office? Please name them: ____

Have your parents or siblings ever had any of the following issues?

Under bite □ Yes □ No *Excessive overbite* □ Yes □ No *Unusual dental problems/missing teeth* □ Yes □ No

If yes, explain: ____

Do you think any of your work or leisure activities affect your teeth or jaws? Please explain: ________________________________

____

Your answers are for our records only and are confidential.

ALLERGIES

Do you have **any** allergies? □ Yes □ No If yes, please explain: ____

For any food related allergies listed above, does adverse reaction occur with contact alone or only when ingested?

____

MEDICAL HISTORY

Have you ever been hospitalized or had a major operation? □ Yes □ No If yes, please explain: ____

Are you taking any medications (including over the counter)? □ Yes □ No If yes, please list: ____

Do you have any mouth habits (e.g., nail biting, finger sucking, etc.)? □ Yes □ No If yes, please explain: ____

Do you have a history of any of the following?

Autism	□ Yes □ No	Asperger's	□ Yes □ No	Sensory processing disorder	□ Yes □ No
Developmental delay	□ Yes □ No	Speech delay	□ Yes □ No	Anxiety	□ Yes □ No
Depression	□ Yes □ No	ADD	□ Yes □ No	Hearing loss	□ Yes □ No
Down syndrome	□ Yes □ No	ADHD	□ Yes □ No	Eating disorder	□ Yes □ No
Brain injury	□ Yes □ No	Apraxia	□ Yes □ No	Asthma	□ Yes □ No

Now, or in the past, have you had any of the following?

Birth defects/hereditary problems	□ Yes □ No	Cancer, tumor, radiation/chemotherapy	□ Yes □ No
Injuries to face, head or neck	□ Yes □ No	Endocrine or thyroid problems	□ Yes □ No
Arthritis or joint problems	□ Yes □ No	Diabetes	□ Yes □ No
Immune system problems	□ Yes □ No	Osteoporosis	□ Yes □ No
Seizures	□ Yes □ No	Fainting spells	□ Yes □ No
Frequent headaches/migraines	□ Yes □ No	High/low blood pressure	□ Yes □ No
Anemia/excessive bleeding/bruising	□ Yes □ No	Heart murmur	□ Yes □ No
Rheumatic heart disease	□ Yes □ No	Skin disorder (other than common acne)	□ Yes □ No
Frequent ear infections	□ Yes □ No	HIV or sexually transmitted disease	□ Yes □ No
Tonsil or adenoid condition	□ Yes □ No		

For females, are you currently pregnant? □ Yes □ No If yes, when is your expected due date? ___________________________

DENTAL HISTORY

Now, or in the past, have you had any of the following?

Sensitive or sore teeth	□ Yes □ No	Mouth breathing habit	□ Yes □ No
Congenitally missing teeth	□ Yes □ No	Tooth grinding/ clenching	□ Yes □ No
Permanent or extra teeth removed	□ Yes □ No	Clicking/locking in jaw joints	□ Yes □ No
Chipped or injured teeth	□ Yes □ No	Soreness in jaw muscles	□ Yes □ No
Lost or broken filings	□ Yes □ No	Treatment for "TMJ" or "TMD"	□ Yes □ No
Jaw fractures	□ Yes □ No	Bleeding gums, bad taste or mouth odor	□ Yes □ No
Frequent canker/cold sores	□ Yes □ No	Diagnosis of gum disease	□ Yes □ No
Root canals	□ Yes □ No	Food impaction between teeth	□ Yes □ No

Is there any additional information we should know? If yes, please explain: ____

____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. Furthermore, I understand that it is my responsibility to inform the office of any changes in my medical status.

____ ____________________________________

Signature of Patient Date

HIPAA Acknowledgement

**You may refuse to sign this acknowledgement.*

**Notice of Privacy Practices is available on our website and at our front desk.*

I, ____, have reviewed Erhart Orthodontics' Notice of Privacy Practices.

____ ______________________

Patient's Signature **Date**

Disclosure Permission

I authorize Erhart Orthodontics to discuss health information with the following individuals:

____ _____________________________________

Name **Relationship to patient**

____ _____________________________________

Name **Relationship to patient**

____ _____________________________________

Name **Relationship to patient**

I authorize Erhart Orthodontics to leave voicemail messages regarding patient information at the following phone numbers:

____ _____________________________________

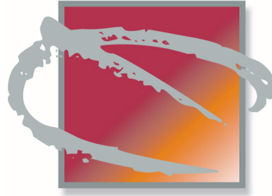
Phone number **Contact name/Relationship to patient**

____ _____________________________________

Phone number **Contact name/Relationship to patient**

____ ___________________________________

Patient's Signature **Date**



Erhart Orthodontics, P.C.

MICHAEL ERHART DDS

Dental Insurance Form

Erhart Orthodontics is not contracted with any insurance companies. However, we will submit claims to your insurance company on your behalf.

Payment in full is due from the patient and all insurance payments will be sent directly to the policyholder. We also offer interest-free payment plans on full treatment.

***Please contact your insurance company prior to your first visit to check for any waiting periods or exclusions and to verify your out-of-network orthodontic benefits*.**

Date: ______________________

Please provide the following information so we can submit claims to your dental insurance company:

Dental insurance company name: ____

Dental insurance company phone number: ____

Policyholder name: ____

Policyholder birthdate: ___________________________

Policyholder ID number or social security number: ____________________________________

Policyholder employer: ____

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