Darrel R. Sherman, D.D.S., M.S.
DIPLOMATE AMERICAN BOARD OF ORTHODONTICS
Patrick R. Briscoe, D.D.S., M.S.
DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

Today's Date: ______________________________

PATIENT INFORMATION:

____
Last First Middle

Name Preferred: ____________________ ☐ Male ☐ Female Date of Birth: _____/____/____ Age: ____________

Address: ____
City State Zip

Phone number: (This number will be used for appointment reminders) ________________________

Other family members seen in our office, and their relationship to the patient: ______________________________

How did you hear about our office? (Please check all that apply)

Your dentist
Your hygienist
Advertisement from child's school program
Banner at school
T-shirts worn in community
Your neighbor ______________________
Drive by
Phone book
Your friend ______________________
Internet
Staff member
Family member ______________________
Other ______________

Orthodontic Concerns? ____

MOTHER'S INFORMATION: 1) Do you have legal custody of the child? YES NO 2) Does the child reside with you? YES NO

____ Date of Birth: _____/____/____
Last First Middle

Address: ____
City State Zip

Home Phone: __________________ Work Phone: __________________ Cell Phone: __________________

Email: ________________________________ IF MARRIED, SPOUSE'S NAME: ______________________

Employer: ____________________________ Occupation: ______________________ How long there? ________

FATHER'S INFORMATION: 1) Do you have legal custody of the child? YES NO 2) Does the child reside with you? YES NO

____ Date of Birth: _____/____/____
Last First Middle

Address: ____
City State Zip

Home Phone: __________________ Work Phone: __________________ Cell Phone: __________________

Email: ________________________________IF MARRIED, SPOUSE'S NAME: ______________________

Employer: ____________________________ Occupation: ______________________ How long there? ________

IF THE PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:
What school does the child attend? ______________________________Grade ____________

Who is accompanying the child today? ______________________________ Relation: ______________________

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

Name: ____________________________________ Relation: ______________________________

Home #: ______________________ Work #: ______________________ Cell #: ________________

FINANCIAL RESPONSIBLE PARTY INFORMATION: (This person must be present at time of contract signing)

____ Date of Birth: _____/____/____

Last First Middle

Address: ______________________________ City: ______________ St: ______ Zip Code: __________

Home Phone: ____________________ Work Phone: ____________________ Cell Phone: ____________________

Email: ______________________________ Social Security #: ______________________________

Employer: ____________________ Occupation: ____________________ How long there? __________

PRIMARY DENTAL INSURANCE: Orthodontic Coverage? ☐ Yes ☐ No Maximum Amount: $ ____________________

Insurance Company Name: ____________________ Insurance Company Phone #: ____________________

Group #: ____________ Employer: ____________________ ID#: ____________________

Insured's Name: ____________________ Relationship to Patient: ____________________

Insured's address: ______________________________ Home phone: ____________________

Insured's Date of Birth: ___/___/___ Insured's Social Security #: ____________________

DENTAL ASSESSMENT/HISTORY: Patient's Dentist: ____________________ Last Visit: ______________

Has an orthodontist been consulted previously? ☐ Yes ☐ No If Yes, explain: ______________________________

Antibiotics required prior to dental visits? ☐ Yes ☐ No If Yes, explain: ______________________________

Has the patient had any of the following dental problems? (Please circle Yes or No)

Jaw Joint Pain/Tenderness	Yes	No	Tooth/Jaw Trauma	Yes	No
Finger/Thumb Habit	Yes	No	Does your jaw lock open?	Yes	No
Do you grind your teeth at night?	Yes	No	Do you clench your teeth?	Yes	No
Lip/Tongue Biting	Yes	No	Tongue Thrust	Yes	No
Missing Permanent Teeth	Yes	No	Extra Permanent Teeth	Yes	No
Allergy to Dental Anesthetics	Yes	No	Allergy to Latex	Yes	No

MEDICAL ASSESSMENT/HISTORY: Patient's Physician: ____________________ Last Visit: ______________

Does the patient have current or previous history of the following conditions? (Please circle Yes or No)

Abnormal Bleeding	Yes	No	Heart Problems	Yes	No	Diabetes	Yes	No
Plastic/Metal Allergy	Yes	No	Cancer or Tumor	Yes	No	Asthma	Yes	No
Rheumatic Fever	Yes	No	Fainting or Dizziness	Yes	No	Hepatitis	Yes	No
Epilepsy/Convulsions	Yes	No	Anemia	Yes	No	Hemophilia	Yes	No
Thyroid Problems	Yes	No	High Blood Pressure	Yes	No	Tuberculosis	Yes	No
Kidney/Liver Problems	Yes	No	Hearing Impairment	Yes	No	Mouth Breathing	Yes	No
Tonsils/Adenoid Problems	Yes	No	Chronic Sinus/Allergies	Yes	No	HIV +/AIDS	Yes	No
Chronic Headaches	Yes	No	Fever Blisters	Yes	No	Tobacco Use	Yes	No
Other Disabilities	Yes	No	Gastrointestinal problems	Yes	No	**Pregnant Now**	Yes	No

Please explain any previous, or ongoing, medical conditions, problems, surgeries, etc.:______________________________

____

List any medications being taken, and their purpose: ______________________________

____

Please list any allergies to medications: ______________________________

AFFIRMATION: I affirm that the information I have given is correct to the best of my knowledge. The information will be held in strictest confidence. It is my responsibility to inform this office immediately of any changes in medical status.
I certify that I am or my child, is covered by the above-listed insurance and assign directly to Sherman, Briscoe and Wilkinson Orthodontics all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of all information necessary to secure the payment of benefits, and the use of this signature on all insurance submissions, whether manual or electronic.

______________________________ ______________________________

Signature of Responsible Party Date

FOR OFFICE USE ONLY: Treatment Coordinator: ____________ Date: ______________Blood Pressure: ______________

Comments: ____