Crescent Moon
ORTHODONTICS
Michael R. Zetz Jr., DMD, MS

PATIENT INFORMATION Appointment Date: _____

Name: _____ Preferred greeting: _____
Date of birth: _____ Sex: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone:_____ ○Home ○Cell ○Work Phone: _____ ○Home ○Cell ○Work
Phone: _____ ○Home ○Cell ○Work
Email: _____
Employer: _____ Work Phone: _____ SS#: _____
Marital status: ○ Married ○ Separated ○ Divorced ○ Single ○ Widowed
Spouse: _____ Work Phone: _____ Cell: _____

Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY

○ Self
○ Other _____
Address (if different) _____
Phone (if different) _____

INSURANCE INFORMATION

Name of insured (primary**)**: _____SS#: _____ Date of birth: _____
Employer: _____ Insurance Co: _____
Ins Co. address: _____ Ins. Co. Phone: _____

Name of insured (secondary**)**: _____SS#: _____ Date of birth: _____
Employer: _____ Insurance Co: _____
Ins Co. address: _____ Ins. Co. Phone: _____

CONCERNS

When did you first realize that you might have a problem requiring orthodontic treatment?
_____
What concerns you most about your teeth or jaws? _____
Which of the following best describes your interest in orthodontic treatment?

○ I want treatment
○ I am willing if treatment is necessary
○ I am not sure

DENTAL HISTORY

Dentist: _____ Date of last dental visit: _____

○ Yes ○ No Have there been any injuries to the face, mouth or teeth?
○ Yes ○ No Are you (or have you been made aware of) clenching or grinding your teeth?
○ Yes ○ No Do your jaw joints make clicking, popping or grating sounds?
○ Yes ○ No Do you have chronic headaches or neck and shoulder pain?
○ Yes ○ No Do you have now or have you ever had pain in your jaw joints or in the side of your face or around your ears?
○ Yes ○ No Do you have missing teeth?
○ Yes ○ No Do you have extensive bridges or crowns?
○ Yes ○ No Have you ever had gum disease?
○ Yes ○ No Have you or any member of your family had orthodontic treatment?
If yes, please explain _____
○ Yes ○ No Have you ever worn a splint before?
How often do you brush your teeth?

- ○ Once a day
- ○ Twice a day
- ○ Several times a day
- ○ Occasionally

MEDICAL HISTORY

Physician: _____

○ Yes ○ No Do you have a history of major illness?
If yes, please explain _____
○ Yes ○ No Are you currently under the care of a physician for any medical conditions?
If yes, please explain _____

Please place a check beside the medical conditions which the patient has now or had previously?

○ Anemia	○ Cancer	○ Glaucoma	○ Kidney disease
○ Arthritis	○ Cerebral Palsy	○ Hearing Problems	○ Lung disorders
○ Asthma	○ Cold sores/oral ulcers	○ Heart disorders	○ Nervous disorders
○ AIDS/HIV	○ Diabetes	○ Heart murmur	○ Pneumonia
○ Bleeding disorders	○ Endocrine disorders	○ Hepatitis	○ Rheumatic fever
○ Bone disorders	○ Epilepsy	○ High blood pressure	○ Tuberculosis

○ Other ~ please specify: _____

○ Yes ○ No Do you smoke or chew tobacco?
○ Yes ○ No Do you have any allergies or drug sensitivities? If yes, please explain: _____

Please list any medications presently taking: _____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize my dentist to release any information Including the diagnosis and the records of any treatment or examination rendered to me during the period of such care to third party payers and/or health practitioners. I agree to be responsible for payment of all services. I understand that, when necessary, credit information may be obtained.

X _____ Date: _____
(Signature)