Matthew D. Epperson DMD MSD

Specialist in Orthodontics

WELCOME

DATE ________________

PATIENT INFORMATION

NAME (last) ______________________ (first) ______________________ (middle) ______________

NICKNAME ______________ BIRTHDATE ______/______/______ AGE ______ SEX: M F

ADDRESS (street) ____

(city) ______________________ (state)______ (zip)__________

PHONE (home) ________________ (work) ______________________ (cell) ________________

EMPLOYMENT (company) __________________________ (position)________________________

(how long?) __________________________

SOCIAL SECURITY # ______ – _____ – _________ MARITAL STATUS ________________

GENERAL DENTIST ______________________________________ PHONE ________________

FAMILY PHYSICIAN ______________________________________ PHONE ________________

WHOM MAY WE THANK FOR TELLING YOU ABOUT OUR OFFICE? ________________________________

BEST E-MAIL ADDRESS TO CONTACT YOU ____

I understand that, in order to be provided with the most flexible payment options, a credit inquiry may be necessary.

__________________________ ______________

SIGNATURE OF PATIENT DATE

FAMILY INFORMATION

SPOUSE'S NAME (last) ______________________ (first) ______________________ (m.i.) ______

ADDRESS (street) ____

(city) ______________________ (state)______ (zip)__________

PHONE (home) ________________ (work) ______________________ (cell) ________________

EMPLOYMENT (company) __________________________ (position)________________________

(how long?) __________________________

SOCIAL SECURITY # ______ – _____ – _________ MARITAL STATUS ________________

ORTHODONTIC INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY ____

ADDRESS ____ PHONE ________________

POLICY/GROUP# ___________________________ EMPLOYER_________________________

INSURED'S NAME ________________________ SS# _____ – _____ – ______ DOB ____/____/____

EMPLOYMENT STATUS ☐ Full time ☐ Part time ☐ Retired

SECONDARY INSURANCE COMPANY ____

ADDRESS ____ PHONE ________________

POLICY/GROUP# ___________________________ EMPLOYER_________________________

INSURED'S NAME ________________________ SS# _____ – _____ – ______ DOB ____/____/____

EMPLOYMENT STATUS ☐ Full time ☐ Part time ☐ Retired

PLEASE COMPLETE THE BACK OF THIS FORM

EMERGENCY INFORMATION

WHOM SHOULD WE CONTACT IN CASE OF AN EMERGENCY?

NAME (last) ______________________ (first) ______________________

(phone) ______________________ (relationship) ______________________

PATIENT HEALTH HISTORY

DOES (OR DID) THE PATIENT HAVE ANY OF THE FOLLOWING CONDITIONS

YES	NO		YES	NO	
☐	☐	Rheumatic fever	☐	☐	Heart problems
☐	☐	Scarlet fever	☐	☐	Heart murmur
☐	☐	Mitral valve prolapse	☐	☐	High/low blood pressure
☐	☐	Asthma or breathing problems	☐	☐	Kidney problems
☐	☐	Epilepsy or seizures	☐	☐	Tuberculosis (TB)
☐	☐	Hepatitis, jaundice or liver problems	☐	☐	Diabetes
☐	☐	Cleft lip/palate	☐	☐	Endocrine or thyroid problems
☐	☐	Tonsils and/or Adenoids removed	☐	☐	Bone disorders
☐	☐	Speech or hearing problems	☐	☐	Radiation treatment
☐	☐	Anemia or bleeding disorders	☐	☐	Mental health or behavioral problems
☐	☐	Sinus or allergies	☐	☐	HIV/AIDS
☐	☐	Latex Allergy	☐	☐	Sexually transmitted disease

Has the patient ever had any type of surgery? ☐ YES ☐ NO

If "YES," please describe: ______________________

Is the patient allergic to any medication(s)? ☐ YES ☐ NO

If "YES," please list: ______________________

Is the patient currently taking any medication (prescription or over-the-counter)? ☐ YES ☐ NO

If "YES," please list: ______________________

Is the patient under a physician's care for the treatment of a medical condition? ☐YES ☐NO

If "YES," please provide physician's name: ______________________

Please describe condition: ______________________

FEMALES: Is there any chance the patient may be pregnant? ☐ YES ☐ NO If "YES," how far along? ________ mos

PLEASE CHECK THE APPROPRIATE BOX CONCERNING THE PATIENT'S DENTAL HISTORY

YES	NO		YES	NO	
☐	☐	Trauma to the teeth and/or face	☐	☐	Click or pop of jaw joints
☐	☐	Finger/thumb sucking habit	☐	☐	Jaw pain
☐	☐	Cheek or lip biting	☐	☐	Pain around the ear
☐	☐	Clench or grind teeth	☐	☐	Frequent headaches
☐	☐	Mouth breather	☐	☐	Smoking
☐	☐	Bleeding gums	☐	☐	Aware or concerned about over or under developed jaw?
☐	☐	Sensitive teeth	☐	☐	Are there any family members with similar tooth/jaw relationship?
☐	☐	Frequent cold sores	☐	☐	Is the patient concerned about the appearance of his/her teeth?
☐	☐	Periodontal disease/treatment	☐	☐	Has patient ever been told he/she needs to take antibiotics before dental treatment?

What is your primary concern (why are you here)? ______________________

How does the patient feel about braces? ______________________

Has the patient had any previous orthodontic consultation(s) and/or treatment? ☐ YES ☐ NO

If "YES," please explain: ______________________

Have there been any injuries to the face, mouth, teeth or chin? ☐ YES ☐ NO

If "YES," please explain: ______________________

Date of last dental visit ______________ How often does patient visit dentist? ______________

I have received a copy of the Notice of Privacy Practices

I have read and understand the above questions. The information that I have given is correct to the best of my knowledge. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes to this history record or medical/dental status I will inform this practice.

______________________ SIGNATURE OF PATIENT

______________ DATE