WERMERSON ORTHODONTICS

WELCOME, were glad you're here!

Today's Date:_____

Name: (LAST, FIRST, MI) _____ I prefer to be called:_____

Birthdate: ____/____/____ Age: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Address: _____
STREET APT/CONDO # CITY STATE ZIP

E-Mail Address: _____ SS #:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext:_____

Employer: _____ Employer's Address: _____

Occupation: _____ How long there? _____

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:** _____

Spouse Information

His/Her Name: _____ Employer: _____

Work Phone: _____ Ext: _____ SS #: _____ Birthdate: ____/____/____

Person Responsible for Account:

Work Phone: _____ Ext: _____ Home Phone: _____ Cell Phone: _____

Billing Address: _____ Relation: _____

SS #: _____ Employer: _____

Orthodontic Insurance

Primary

Orthodontic Coverage: ☐ Yes ☐ No Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____ Ins. Co. Phone: _____

Insurance Co. Address: _____

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: _____ Ins. Co. Phone: _____

Insurance Co. Address: _____

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 could contact?

His/Her Name: _____ **Relation:** _____

Work Phone: _____ **Home Phone:** _____

Medical History

Do you have a personal physician? ☐ Yes ☐ No Physician's Name: _____

Phone: _____ Date of Last Visit: _____

CONTINUED ON BACK

6801 South Minnesota Avenue, Sioux Falls, SD 57108
7109 West 26th Street, Sioux Falls, SD 57106
1515 West Holly Boulevard, Brandon, SD 57005

Phone: (605) 274-0555
WermersonOrthodontics.com

Medical History *continued*

Your current 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: _____

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____ Are you nursing? ☐ Yes ☐ No

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

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

Please list any serious medical condition(s) that you have ever had: _____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Dental Anesthetics	Y	N	Penicillin
Y	N	Any Metals / Plastics	Y	N	Erythromycin	Y	N	Tetracycline
Y	N	Codeine	Y	N	Latex	Y	N	Other

Please list any other drugs / materials that you are allergic to: _____

Dental History

What are the main concerns you would like orthodontics to accomplish? _____

Have you ever had or been evaluated for orthdontic treatment? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

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

Do you like your smile? ☐ Yes ☐ No

Have you ever had an injury to your (please circle): Mouth Teeth Chin

Do you have speech problems? ☐ Yes ☐ No

Do you generally breathe through your mouth? ☐ Yes ☐ No If yes, please circle: While Awake? While Asleep?

Do you have any dental implants? ☐ Yes ☐ No

Have you ever taken Fosamax, or any other biphosphonate? ☐ Yes ☐ No

Do you smoke or use tobacco in any form? ☐ Yes ☐ No

Do you require antibiotics before dental care? ☐ Yes ☐ No

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.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and 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 during diagnosis and treatment with my informed consent.

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 _____

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I verbally reviewed the medical / dental information above with the patient named herein.

Initials: _____ **Date:** _____ **Doctor's Comments:** _____

WERMERSON ORTHODONTICS

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I, _____ have received a copy of Wermerson Orthodontics
(Parent/Guardian print name) Notice of Privacy Practices.

_____

(Please print Patient Name)

_____

(Patient/Parent/Guardian signature)

_____

(Date)

For Wermerson Orthodontics office use, in the event the Notice of Privacy Practices isn't signed. We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

- ○ Individual refused to sign
- ○ Communications barriers prohibited obtaining the acknowledgement
- ○ An emergency situation prevented us from obtaining the acknowledgement
- ○ Other (Please specify)
