sierk orthodontics
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Patient Information

Patient's Name _____ _____ Date _____
LAST FIRST MIDDLE SEX

Address _____
STREET CITY STATE ZIP

Home Phone _____ Date of Birth _____ Age _____ Parent/Guardian Name _____

School _____ Grade _____ Siblings _____

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

Responsible Party Information

Name _____ Marital Status _____
LAST FIRST MIDDLE

Residence _____
STREET CITY STATE ZIP

Mailing Address _____
STREET CITY STATE ZIP

How long at
this address? _____ Home Phone _____ Work Phone _____

Cell Phone _____ Email Address _____

Previous Address
(if less than 3 yrs.) _____
STREET CITY STATE ZIP

Social Security No. _____ Date of Birth _____ Relationship to Patient _____

Employer _____ Occupation _____ Yrs. Employed _____

Name 2nd Resp. Party _____
LAST FIRST MIDDLE

Address _____ Home Phone _____ Work Phone _____
STREET CITY STATE ZIP

Social Security No. _____ Date of Birth _____ Relationship to Patient _____

Employer _____ Occupation _____ Yrs. Employed _____

Orthodontic Insurance Information

Insured's Name _____ Insured's Soc. Sec. No. _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Ins. Co. Phone No. _____

2nd Insured's Name _____ Insured's Soc. Sec. No. _____

2nd Insurance Company _____ Group No. _____ Local No. _____

2nd Insurance Co. Address _____ Ins. Co. Phone No. _____

Emergency Information

Name of nearest relative
not living with you _____ Relationship _____ Phone No. _____

Dental History

Date History Reviewed_____

Why does patient desire an examination (bite, crookedness, "TMJ", etc.)?_____

Patient's Dentist _____ When was your last dental visit?_____

Has patient had previous orthodontics?_____ If so, state the orthodontist, where, when and treatment received:

_____

**Concerns about X-rays?_____

	NO	YES		NO	YES
Teeth Throb or Ache, Sensitivity to Hot or Cold	❑	❑	Bone Loss, Periodontal Disease	❑	❑
Irritations to Cheek, Lip, Tongue, Palate	❑	❑	Any Oral Surgeries	❑	❑
Canker Sores, Cold Sores, Cyst, Abscesses	❑	❑	Facial Trauma/Injury	❑	❑
Lip, Cheek or Tongue-Biting	❑	❑	Chipped or Injured Teeth	❑	❑
Food Impaction Between Teeth	❑	❑	Missing or Extracted Teeth	❑	❑
Bleeding Gums, Gingivitis	❑	❑	Difficulty in Breathing, Chewing	❑	❑
Gum Recession	❑	❑	Mouth-breather	❑	❑
Other _____			Thumb or Finger-sucking Habit	❑	❑

Medical History

Patient's Physician and/or Health Care Provider_____

Health Status (good, fair, poor, continuing problems, etc.)?_____

Under a Physician's care?_____ If yes, for what?_____

List of Medications — Prescription & "Over the Counter" _____

List any Allergies:_____

List any Types of Surgery:_____ Blood Transfusions?_____

	NO	YES		NO	YES
Diabetes	❑	❑	Arthritis	❑	❑
Heart Disease	❑	❑	Tuberculosis or Lung Problems	❑	❑
Congenital Heart Problems/Defects	❑	❑	Ear Infections, Ringing in Ears	❑	❑
High/Low Blood Pressure	❑	❑	Sinus/Airway Problems	❑	❑
Heart Murmur or Valvular Problems	❑	❑	Hayfever or Asthma	❑	❑
Rheumatic Fever	❑	❑	Treated with X-Ray Therapy	❑	❑
Prosthetic Hip or Joint	❑	❑	Herpes, Epstein Barr Virus, etc.	❑	❑
Blood Disease, Hemophilia, Anemia	❑	❑	AIDS, AIDS Related Complex	❑	❑
Kidney Disorder	❑	❑	Smoking or Alcohol use	❑	❑
Hepatitis	❑	❑	Women — Are you Pregnant?	❑	❑
Neurological Disorders	❑	❑	Other diseases/disorders/etc._____		

TMJ - Facial Pain History

	NO	YES		NO	YES
Clench/Grind your Teeth	❑	❑	Clicking, Popping, etc., Sounds from Jaw Joint	❑	❑
Jaw Open/Close Irregularly	❑	❑	Ever Received a Severe Blow to the Jaw or Head	❑	❑
TMJ Related Head or Neckaches	❑	❑	Are you Under a Lot of Stress?	❑	❑
Muscles Tire with Normal Chewing	❑	❑	Pain/Tenderness in your Cheek/Facial Muscles	❑	❑
Time of day most TMJ problems occur:_____			Episodes of Limited Jaw Opening/Closing/Locking	❑	❑

What brings on or starts your TMJ problem:_____

Ever been treated for Jaw Joint Problems, facial muscle spasms or worn a night guard/splint:_____

Describe your problem in words:_____

_____

I have completed the patient information and medical/dental history section to the best of my knowledge and have not withheld any information that may affect either myself or the dental staff during treatment. I understand that, where appropriate, credit bureau reports may be obtained.

Signature (Parent's/Guardian's signature if minor)_____ Date_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

(please print name)

Signature: _____ **Date:** _____

FOR OFFICE USE ONLY_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barrier prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) _____

What's Most Important to You?

We consider your satisfaction to be of utmost importance, and this starts by personalizing your orthodontic experience. Please review the treatment aspects below that our skilled team of professionals can deliver using several state-of-the-art technologies.

(Please rank your top three treatment aspects from 1 to 3)

_____ **Aesthetics: I would prefer it if people don't notice I'm in orthodontic treatment.**

_____ **Colors: I want to have fun displaying different colors (ie on holidays, for sports teams, etc).**

_____ **Comfort: I want the highest degree of comfort possible during treatment.**

_____ **Length of Time in Orthodontic Treatment: I want to have a beautiful smile as quickly as possible.**

_____ **Visit Frequency: I want to come to the orthodontist as few times as possible.**

_____ **Appointment Length: I want to sit in the chair for short periods during adjustment appointments.**

_____ **Schedule: I'd like appointments to accommodate my own schedule (before or after school / work).**

_____ **Punctuality: I want to be seen on time for adjustment appointments.**

_____ **Treatment Cost: The down payment and monthly payment are major considerations.**

_____ **Other:** _____