MITCHELL & BOYER ORTHODONTISTS

Welcome To Our Office!

Robert D. Mitchell DDS MS & Ryan A. Boyer DDS MSD

Specialists in Orthodontics

Date _____

PATIENT INFORMATION

Name: _____ _____ Home Phone #: _____
First Middle Last Nickname

Address: _____
City State Zip

Email: _____ Birthday: _____ Age: _____ Sex: ☐ M ☐ F

Employer: _____ Work #: _____ Occupation: _____

Best Time to Reach You: _____ Cell #: _____

☐ Married ☐ Single ☐ Seperated ☐ Divorced ☐ Widowed Spouse's Name & Number: _____

Referred By: _____

In Case of an Emergency, Call (Name & Number) : _____

Other Family Members Seen By Us: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relation: _____

Billing Address: _____

Home Address if different: _____

Home/ Cell #: _____ DL #: _____

Employer: _____ Wk #: _____

SS#: _____ Birthdate: _____

MEDICAL INFORMATION

Physician: _____ Phone #: _____ Date of Last Visit: _____

	YES	NO
Are You Under the Care of a Physician:		
Are You in Good Health:		
Abnormal Bleeding:		
Alcohol/ Drug Abuse:		
Anemia:		
Arthritis:		
Artificial Bones, Joints/Valves:		
Asthma or Hay Fever:		
Blood Transfusions:		
Cancer/ Chemotherapy:		
Colitis:		
Any Heart Disease/Defects:		
Diabetes:		
Difficulty Breathing:		
H.I.V. Positive/AIDS:		
Any High or Low Blood Pressure:		
A History of Fainting or Dizziness:		
Heart Murmur:		
Hemophilia:		
Hepatitis/Liver Problems:		
Handicaps/Disabilities/Hearing Impairment:		
Herpes/Fever Blisters:		

	YES	NO
Hospitalized For Any Reason:		
Kidney Problems:		
Pacemaker:		
Psychiatric Problems:		
Radiation Treatment:		
Rheumatic Fever/Scarlet Fever:		
Any Seizure Disorder:		
Sickle Cell Disease/Traits:		
Sinus Problems:		
Stroke:		
Thyroid Problems:		
Tuberculosis:		
Ulcers:		
Venereal Disease		
Allergic to Latex / Metals:		
Ever taken Fosamax, or any other bisphosphonate?		
For Women:		
Are you using a prescribed method of birth control?		
Are you pregnant?		
Week #		
Are you nursing?		

Please discuss any medical problems that you have: _____

List Any Medications or Supplements Currently Taking: _____

Are You Allergic to Anything, if so what: _____

Any other disease, condition, or problem not listed above that we should know about: _____

DENTAL HISTORY

Dentist: _____ Phone #: _____ Date of Last Visit: _____

	YES	NO
Have You Been Evaluated or had Orthodontic Treatment Before:		
Have You Seen a General Dentist in the Last Year:		
Has Your Mouth, Face or Teeth Been Injured by a Fall or Accident:		
Frequent Headaches:		
Are You Aware of Any "Gum" Problems:		
Have You Had Tonsils or Adenoids Been Removed:		
Know of Any Missing or Extra Permanent Teeth:		
Pain/Clicking/Popping in Jaw Joint (TMD/ TMJ):		
Require Antibiotics Before Dental Treatment:		
Have You Ever Had Serious Problem With Any Previous Dental Work:		

	YES	NO
Brush & Floss Teeth Daily:		
Thumb/Finger Sucking:		
Mouth Breather:		
Finger Nail Biting:		
Tongue Thrusting:		
Clench/Grind Teeth:		
Speech Problems:		
Smoke or Use Tobacco Products:		
Currently in Any Pain:		
Do You Like Your Smile:		

In Your Own Words What is the Orthodontic Problem: _____

_____

DENTAL INSURANCE

Primary Dental Insurance

Insured's Name #1 _____

Soc. Sec. # of Insured _____

Birthdate of Insured ____/____/____

Employer _____

Insurance Company _____

Insurance Company Phone # (____) _____

Insurance Company Address _____

_____

Insurance Group # _____

Secondary Dental Insurance

Insured's Name #2 _____

Soc. Sec. # of Insured _____

Birthdate of Insured ____/____/____

Employer _____

Insurance Company _____

Insurance Company Phone # (____) _____

Insurance Company Address _____

_____

Insurance Group # _____

I hereby authorize release of any information to other health care providers, insurance companies and business associates including personal health information, as well as administrative data which is not strictly dental or medical in nature. I additionally authorize payment of insurance benefits directly to Mitchell & Boyer Orthodontists.

I am giving my consent to use and disclose my protected health information to carry out treatment, payment activities and health care operations.

I certify that the information on this form is complete and true to the best of my knowledge. I also understand that this information is held in the strictest confidence and it my responsibility to inform the office of any changes in my medical status. I understand that when appropriate, credit bureau reports may be obtained.

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payments and deductibles that my insurance does not cover.

_____

Signature Date

This office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA

******* Please note that some longer procedures are only done in the mornings during school hours *******

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The highest commitment to excellence.

Member American Association of Orthodontists