Stang Family Orthodontics
Christine F. Stang, DDS, MSD
Frederick N. Dibbs, DDS, MS

ORTHODONTIC PATIENT HISTORY

PATIENT INFORMATION

Name:____Date of Birth:___/___/_____Sex: M F
(First) (Last) (Title)

Address: ____
(Street) (City) (State) (Zip)

Home Phone: ______________ Cell Phone: _______________ E-mail: ____________________________

Best way(s) to receive appointment reminders (Please check all that apply):

___Phone _____E-mail _____Text Message (Carrier e.g. Verizon:__________________)

Name of Dentist:__________________________________

How did you hear about our office (Please check all that apply):

__Dentist __Friend __Coworker __Internet Search __Our Website __Other:__________________

Is this your first orthodontic exam? __Yes __No

DENTAL INSURANCE INFORMATION

Please complete only if you have DENTAL coverage or Reimbursement plans

Subscriber Name:________________________________Date of Birth:___/___/___ Employer: __________
(First) (Last)

Your relationship to subscriber (circle one): Self Spouse

Insurance Name: ____________________ Policy #: __________________Group #: ________________

Insurance Address: ____
(Street) (City) (State) (Zip)

MEDICAL HISTORY OF PATIENT

Question		
History of joint swelling, asthma, TB, heart or kidney/liver ailment, epilepsy, rheumatic fever, or other major illness?	YES	NO
Is there a tendency to faint or become dizzy?	YES	NO
Have you had tonsils or adenoids removed?	YES	NO
Do you bleed easily, or is bleeding hard to stop?	YES	NO
Do you have allergies? (Latex, Sulpha, Penicillin, Novocaine, Others)	YES	NO
Are you under a physician's care at present?	YES	NO
Have any medical x-rays been taken in the past 6 months?	YES	NO
Do you have any infectious diseases passed via saliva or blood? (HIV, Hepatitis C, Herpes)	YES	NO
Are you currently taking any medications? If yes, please list:	YES	NO

DENTAL HISTORY

Question			
Approximately when was your last dental check up?			
Have there been any injuries to your teeth? (Falls, blows, chips)?	YES	NO	
Have you been told you have or been treated for gum disease?	YES	NO	
Do you breathe through the mouth or are the lips often parted?	YES	NO	
Were there habits that might have caused the teeth to move?	YES	NO	
Has any other family member ever had orthodontic treatment?	YES	NO	
Who first noticed the need for orthodontic care?	Dentist	Parent	Patient
Are you concerned about the appearance of your smile?	YES	NO	
Do you want your teeth straightened?	YES	NO	
Are you aware some appointments will infringe on school or work time?	YES	NO	

What would you most like to have orthodontic treatment accomplish? ______________________________

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We make every effort to help keep orthodontics affordable for our patients. We offer several affordable and easy payment options for your convenience. Some office procedures require full payment at time of service. In the event that payments are not received within 60 days of their due date, I agree to pay all costs of collections, including, but not limited to, reasonable attorney's fees. By signing this form I agree to all the terms above. Any information obtained will be kept in strict confidence.

I certify that I have read and understand the above information and to the best of my knowledge, the above questions have been accurately answered. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such orthodontic care to third party payers and/or health practitioners. I authorize and request my insurance carrier to pay directly to the dentist otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient or parent if a minor______________________________ **Date**______________________