Lang orthodontics

Today's Date _____

TELL US ABOUT YOU

Name _____ Prefers to be called _____
First Middle Last

Address _____
Street City Zip

Phone: Home (____)_____-_____ Cell (____)_____-_____ Work (____)_____-_____

Date of Birth _____ □ Male □ Female

Marital Status: □ Single □ Married □ Partnered □ Separated □ Divorced □ Widowed

Employer: _____ Occupation: _____

Email: _____

Spouse's Name _____

Dentist _____ Date of last cleaning/visit _____

RESPONSIBLE PARTY INFORMATION

□ Same as Above

Responsible Party Name _____ Relation _____
First Middle Last

Address _____
Street City Zip

Phone: Home (____)_____-_____ Cell (____)_____-_____ Work (____)_____-_____

Employer: _____ Occupation: _____

Email: _____

PRIMARY DENTAL INSURANCE INFORMATION

Insured's Name _____ Relationship to patient _____

Date of Birth _____ Social Security Number _____

Insurance Company _____ Group No _____ Local No _____

Insurance Company Address _____ Phone No _____
Street City Zip

Do you have dual coverage? □ Yes □ No

Insured's Name _____ Relationship to patient _____

Date of Birth _____ Social Security Number _____

Insurance Company _____ Group No _____ Local No _____

Insurance Company Address _____ Phone No _____
Street City Zip

814 Pierremont Rd. Shreveport, LA 71106
129 East 5th St. Natchitoches, LA 71457
(318) 861-0700 Fax: (318) 868-2468
www.GeauxSmile.com

HEALTH HISTORY

(please check if patient has condition or received treatment)

□ ADD/ADHD/Behavioral Issues
□ AIDS/HIV Infection
□ Allergy (Food, Drug or Other)
Food _____
Drug _____
Other_____
□ Arthritis
□ Artificial Joints/Valves
□ Asthma/Breathing Problems
□ Bone Disorder/Bisphosphonates
□ Blood Disorder/Anemia
□ Cancer/Tumors
□ Cold Sores
□ Diabetes or Hypoglycemia
□ Emotional Disturbances
□ Endocrine Problems
□ Eye/Hearing/Speech Impairment
□ Handicap/Disabilities
□ Hepatitis A, B, or C
□ Herpes
□ Heart Condition
Murmur
Chest Pain/Angina
□ High/Low Blood Pressure
□ Latex/plastic Allergy
□ Metals/Nickel Allergy
□ Radiation Therapy
□ Rheumatic Fever/Disease
□ Seizures/Stroke/Epilepsy
□ Tuberculosis

Other Condition (s) not listed _____
Please explain all checked responses _____
List any medications _____
Are you under the care of a physician at the current time and what for _____
Are you pregnant _____
Family Physician _____ Phone (____)_____-_____ Date of Last Visit _____

DENTAL HISTORY

(please check if patient has condition or received treatment)

□ Any injuries to face, mouth or teeth
□ Thumb, finger or lip sucking habit
□ continuing □ discontinued
□ Tonsils removed
When _____
□ Mouth breathing when asleep, awake
□ Any known missing permanent teeth
□ Any known extra permanent teeth
□ Any teeth removed by extraction
When _____
□ Is there a tongue thrust problem
□ Musical Instrument _____
□ Any clenching/grinding of teeth
□ Day □ Night □ Both
□ Frequent Headaches
□ Adenoids removed
When _____
□ Any pain, popping or locking on opening or closing jaw movement
□ Any muscle tenderness or stiffness in jaw or neck area
□ Any ringing in ear or dizziness
□ Any previous treatment of TMJ problems
□ Snores or breathes heavily when sleeping

Please explain all checked responses or any additional comments _____
_____
Please list your chief concern(s) and what you would like your orthodontic treatment to accomplish _____
_____
Have you ever been □ evaluated or □ treated by any orthodontist? If yes, complete below.
Orthodontist: _____ Date last seen: _____
Address:_____
Type of treatment: _____

RELEASE

I understand that the information that I have given is correct to the best of my knowledge, that it will be held to 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 the necessary dental services that I may need.
Responsible Party 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 deductible that my insurance does not cover. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office.
Responsible Party Signature _____ Date _____

I understand that my records may be used for educational or promotional purposes.
Responsible Party Signature _____ Date _____