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Diplomate, American Board of Orthodontics

Patient Information

Date _____ Adult Minor
Patient's Name _____ Birthdate _____ Age _____ M F
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell _____ Email _____
If patient is a minor, give custodial parents or legal guardian's name _____
Whom may we thank for referring you to our office? _____
Where have you heard or seen Dr. Iverson's name in our community? (circle all that apply) *News Paper- Schools - Sporting events - Fairs - Internet- Community Events:* _____ (please specify)
What is your chief concern with your (or child's) teeth? _____
Do you use Facebook? _____

Responsible Information/Primary Insurance

Marital Status: Married Separated Divorced Widowed Single
Name _____ Email _____
Residence _____
Mailing Address _____
How long at this address _____ Home phone _____ Work _____ Cell _____
Employer _____ Addr _____ Phone _____
Insurance Company _____ Group No. _____
Subscriber ID# _____ Birth date _____ Relationship to patient _____
Insurance Co. Address _____
Phone _____ Ins. Auth Signature _____
(Office to Fill out) Benefits Max _____ % _____ Age _____ Payment Sch _____

SPOUSE AND/OR SECONDARY INS COVERAGE

Name _____ Email _____
Mailing Address _____
Employer _____ Addr _____ Phone _____
Insurance Company _____ Group No. _____
Subscriber ID# _____ Birth date _____ Relationship to patient _____
Insurance Co. Address _____
Phone _____ Ins. Auth Signature _____
(Office to Fill out) Benefits Max _____ % _____ Age _____ Payment Sch _____

Emergency Contact

Emergency Contact _____ Phone _____
Relationship to patient _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

Updates (date and initial) _____

Patient _____

Physician _____ City _____ Phone _____

Does the patient:

- | | | |
|--------------------------|--------------------------|--|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Have any health problems? Explain _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Take any medications? List _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have allergic reactions to medications? List _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Currently see a physician? Explain _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Receive blood transfusion? Reason _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Had their tonsils and adenoids removed? When _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Take medication for immunosuppressive disease? Explain _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Take any medications for dietary conditions? i.g. phenphen _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you currently or ever taken bisphosphonates? Explain _____ |

Please check if patient has had any of the following:

	Yes	No		Yes	No		Yes	No
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Hives/Rash	<input type="checkbox"/>	<input type="checkbox"/>	Emotional Problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Nervous/Anxious	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Bone Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Growth Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Herpes (Fever Blisters)	<input type="checkbox"/>	<input type="checkbox"/>
Developmental Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>

Any other conditions or problems that we should know about? _____

Growth information for patients under 16- Because growth can be an important factor in orthodontic treatment planning, your answers to the following questions are needed to aid our treatment alternatives: Has patient:

- | | | | |
|--|------------------------------|-----------------------------|---|
| Reached puberty | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Girls- started menstruation? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When? _____ |
| Boys- Voice changed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When? _____ |
| Do you feel growth is completed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Father's Height _____ Mother's Height _____ |
| Have siblings or parents been treated with orthodontics? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |

Dentist _____ City _____ Phone _____

- Frequency of dental checkups: Twice a yr Once a yr Only if problem exists Never Date of last visit _____
- Is there any unfinished care to be completed with your dentist? Yes No Explain: _____
- Are you frightened about dental treatment? Yes No Explain: _____
- Have you had any unpleasant experience in a dental office? Yes No Explain: _____
- Have you had any face or dental injuries? Yes No Explain: _____
- Do you play any musical instrument? Yes No What instrument? _____
- Have you consulted with an orthodontist previously? Yes No With whom? _____
- Have teeth (either primary or permanent) been removed? Yes No Explain: _____
- Have you had any previous orthodontic treatment? Yes No With whom? _____
- Are you satisfied with prior treatment? Yes No Explain: _____
- Is there a history of thumb sucking? Yes No How long: _____

Please check if there is a history of:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Clenching teeth | <input type="checkbox"/> Muscular soreness around head and neck | <input type="checkbox"/> Jaw joint soreness | <input type="checkbox"/> Jaw joint popping |
| <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Headaches (more than normal) | <input type="checkbox"/> Jaw joint clicking | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Speech problems (If so, what sounds _____) | | <input type="checkbox"/> Mouth breathing: circle awake asleep | |

Is there any other information that may be helpful? _____

Patient's Signature _____ Parent/Guardians signature (if minor) _____

For Office Use Only

T.C.'s Initials _____	Dr. Iverson _____	Date _____
Update _____	Dr. Iverson _____	Date _____