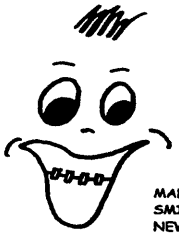

Welcome to the Orthodontic Office of

Dr. Laurie L. Fricke

a professional dental corporation

Specialist in Orthodontics

Thank you for coming to our office. Our goal is to make this a rewarding experience for you. We know the importance of a beautiful smile. . .because a smile is forever.

1 ABOUT YOU

Today's Date: _____

Name: _____
LAST FIRST MI MR. MRS. MS. DR.

I prefer to be called: _____ ❑ Male ❑ Female

Birthdate: ____/____/____ Age: _____ SS#: _____

Home Address: _____

_____
CITY STATE ZIP

❑ Single ❑ Married ❑ Divorced ❑ Widowed

Home # _____ Other # _____

Work # _____ Ext. _____ Other # _____

Employer: _____

Occupation: _____

Whom may we thank for referring you? _____

General Dentist: _____

Has anyone else in your family received care from our office? ❑ YES ❑ NO

Name: _____

2 SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

Work # Ext. SS#:

Person Responsible for Account: _____

Home # _____ Work # _____ Ext. _____

Billing Address: _____

Relationship: _____ SS# _____

Employer: _____

3 ORTHODONTIC INSURANCE

Orthodontic Coverage? ❑ *YES* ❑ *NO*

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone # _____

Group # *(Plan, Local or Policy)*: _____

Insured's Name: _____

Insured's SS#: _____

Relationship to Insured: _____

Insured's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

Name: _____ Relationship: _____

Work # _____ Home # _____

4 MEDICAL HISTORY

Do you have a personal Physician? ❑ *Yes* ❑ *No*

Physician's Name: _____

Your current physical health is: ..... ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ..... ❑ Yes ❑ No

Please explain: _____

_____

_____

_____

_____

CONTINUED ON REVERSE . . .

FOR OFFICE USE ONLY

New Patient Appointment: _____

Diagnostic Records Appointment: _____

Consultation: _____

4 . . . MEDICAL HISTORY

Are you taking any prescription/over-the-counter drugs?

❑ Yes ❑ No

Please list each one: _____

_____

_____

Please list any drugs that you are allergic to: _____

_____

_____

Have you ever had any of the following diseases or medical problems?

❑ No	❑ Yes	Anemia?
❑ No	❑ Yes	Blood Disease?
❑ No	❑ Yes	Hemophilia?
❑ No	❑ Yes	Hepatitis?
❑ No	❑ Yes	Are you immunosuppressed?
❑ No	❑ Yes	Jaundice?
❑ No	❑ Yes	Rheumatic Fever?
❑ No	❑ Yes	Heart Disease?
❑ No	❑ Yes	Tuberculosis?
❑ No	❑ Yes	Diabetes?
❑ No	❑ Yes	Endocrine Problems?
❑ No	❑ Yes	Bone Disorders?
❑ No	❑ Yes	Epilepsy?
❑ No	❑ Yes	Allergic to Latex / Metals?
❑ No	❑ Yes	Handicaps / Disabilities?
❑ No	❑ Yes	Asthma?

5 DENTAL HISTORY

What are the main concerns that you would like orthodontics to accomplish?

_____

_____

_____

Have you ever had orthodontic treatment? ..... ❑ Yes ❑ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ..... ❑ Yes ❑ No

Please check if you have had any of the following:

❑ No	❑ Yes	Muscular soreness around head and neck?
❑ No	❑ Yes	Headaches (more than normal)?
❑ No	❑ Yes	Jaw joint clicking or popping?
❑ No	❑ Yes	Jaw joint soreness?
❑ No	❑ Yes	Ringing in the ears?
❑ No	❑ Yes	Do you like your smile?
❑ No	❑ Yes	Do your gums ever bleed?

Have you ever had an injury to your:

❑ No ❑ Yes ..... Mouth?

❑ No ❑ Yes ..... Teeth?

❑ No ❑ Yes ..... Chin?

Do you generally breath through your mouth?

❑ No ❑ Yes ..... Awake?

❑ No ❑ Yes ..... Asleep?

❑ No ❑ Yes ..... Do you have any missing or extra permanent teeth?

Additional Comments: _____

_____

_____

_____

_____

_____

THANK YOU!

Please read the above information and sign below.

Signature _____ Date _____

We desire to extend as favorable a payment plan as possible, but to do so requires your permission to verify your credit prior to a discussion of treatment fees.

By signing below, I authorize you to verify my credit status.

Signature _____ Date _____