ABO Board Certified Orthodontic Specialists

Offices in Layton and Clinton Utah

Welcome to our office. We do whatever it takes to put a smile on your face. Please help us get to know you by filling out the following information.

PATIENT INFORMATION

Name _____ Date ___/___/___
Nickname_____
Birth date _____/_____/_____ Age_____ M___ F___
Address _____
City _____ State_____ Zip code_____
How long at this address_____
Home # _____ Cell # _____
Marital Status S __ M __ D __ W__
SSN _____
E-Mail address _____
Employer _____
Job title _____No. years employed ___
Work # _____
Dentist-First and Last Name _____
Last visit _____
Favorite sports or hobbies _____
Other_____
Incase of emergency contact _____
Phone # _____ Relationship _____

INSURANCE INFORMATION ___Y ___N

Primary insurance company_____
Insured name _____
Contact # _____ Group # _____
Subscriber # _____ Employer _____
Coverage amount _____% up to _____ max _____ deduct
Secondary insurance company _____
Insured name _____ Birth date ___/___/___
Contact # _____Group # _____
Subscriber # _____ Employer _____
Coverage amount _____% up to _____ max _____ deduct
Third insurance company _____
Insured name _____
Contact # _____ Group # _____
Subscriber # _____ Employer _____
Coverage amount _____% up to _____ max _____deduct

WHO REFERRED YOU TO OUR OFFICE

___ Dentist _____
___ Friend _____
___ Yellow pages _____
___ Internet _____
___ Other _____

SPOUSE'S INFORMATION

Name _____ Birth date____/____/____
Address _____
City _____ State _____ Zip code _____
Home # _____ Work # _____
Employer _____ Job title _____
No. of years employed _____ Marital Status _____
SSN _____ Cell # _____
E-mail address _____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Name _____ Relationship _____
Address _____
City _____ State _____ Zip code _____
Home # _____ Work # _____
Employer _____ Job title _____
Number of years employed _____Marital Status _____
SSN Birth date / /

DO YOU PARTICIPATE IN THE FOLLOWING?

Facebook ___ Twitter ___ Blog ___ LinkedIn ___ Other___

WE WOULD LOVE TO CONNECT WITH YOU ONLINE!

www.coombssmiles.com
www.facebook.com/coombsorthodonticsutah.com
www.coombsorthodonticsutah.blogspot.com

I have been informed of the treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X_____
Patient/Guardian signature Date

I hereby authorize and direct payment of dental benefits otherwise payable to me, directly to Coombs Orthodontics.

X_____
Subscriber signature Date

MEDICAL HISTORY

Physician _____ Date of last visit _____

Address _____ Phone _____

Please circle Yes or No (if yes please fill in details)

Yes No Are you presently taking any medication? _____

Yes No Are you allergic to any medication? _____

Yes No Do you have a history of a major illness? _____

Yes No Have you had any major operations? _____

Yes No Have you ever been involved in a serious accident? _____

Yes No Do you presently or have you ever used tobacco? _____

Please circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/hemophilia	Diabetes	Hepatitis/liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High blood pressure	Radiation/chemotherapy
Asthma or hay fever	Gastrointestinal disorders	HIV/Aids	Rheumatic fever
Bone disorders	Heart problems	Kidney problems	Tuberculosis
Congenital heart defect	Heart murmur	Nervous disorders	Tumor or cancer

Any other medical condition we should be aware of _____

_____

DENTAL HISTORY

What concerns you most about your teeth? _____

_____

Please circle Yes or No (if yes please fill in details)

Yes No Are you presently in any dental pain? _____

Yes No Have you ever experienced any unfavorable reaction to dentistry? _____

Yes No Have you ever lost or chipped any teeth? _____

Yes No Is any part of your mouth sensitive to temperature or pressure? _____

Yes No Do your gums bleed when you brush or floss? _____

Yes No Do you have any type of thumb or tongue habit? _____

Yes No Are you a mouth breather? _____

Yes No Have you ever seen an orthodontist? If yes, who and when? _____

Yes No Would you object to wearing orthodontic appliances (braces) should they be indicated? _____

Yes No Has anyone in your family received orthodontic treatment? _____

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____

Yes No Are you aware of your jaw clicking or popping? _____

Yes No Are you aware of clenching your teeth during the day? _____

Yes No Have you ever been told that you grind your teeth? _____

Yes No Do you have "tension" headaches? _____

Yes No Have you ever experienced chronic ringing in your ears? _____

Yes No If the patient is under age 16, height of parents _____mom _____dad

Yes No Are you aware that some appointments will be during school/work hours? _____

Female patients only:

Yes No Are you pregnant? _____

Yes No Has patient reached puberty? _____ If so at what age? _____

BENEFITS

Benefits of orthodontic treatment: Aesthetics, health, and function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Coombs to perform a complete orthodontic evaluation.

_____ _____

Please print name of person filling out these forms. Relationship to patient

_____ _____

Signature Date