POBANZ ORTHODONTICS

MORE THAN STRAIGHT TEETH. BY A SPECIALIST.

Certified, American Board of Orthodontics

Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you!

PATIENT INFORMATION

Name _____ Date _____

Nickname _____

Birthdate ____/____/____ Age _____ ☐ M ☐ F

Address _____

City _____ State _____ Zipcode _____

Previous address (if less than 3 years) _____

_____

Home Phone _____ Wk # _____

Cell Phone# _____ Marital Status ☐ S ☐ M ☐ D

SSN _____

Employer _____

Job title _____ No. of years employed _____

Dentist _____ Last Visit _____

Favorite Sports or Hobbies _____

Other _____

In case of an Emergency Contact _____

Phone # _____ Relation _____

INSURANCE INFORMATION ☐ YES ☐ NO

Primary Insurance Company _____

Subscriber Name _____

Birthdate ____/____/____ SSN _____

Subscriber # _____ Group # _____

Insurance phone # _____

Secondary Insurance Name _____

Subscriber Name _____

Birthdate ____/____/____ SSN _____

Subscriber # _____ Group # _____

Insurance phone # _____

Check out our website at www.webracem.com

REFERRAL

WHO REFERRED YOU TO OUR OFFICE?

☐ Dentist _____

☐ Friend _____

☐ Yellow Pages _____

☐ Other _____

SPOUSE'S INFORMATION

Name _____ Birthdate ____/____/____

Address _____

City _____ State _____ Zipcode _____

Home# _____ Wk # _____

Employer _____ Job title _____

No. of years employed _____ Marital Status _____

SSN _____

PERSON FINANCIALLY RESPONSIBLE

Name _____ Relation _____

FOR OFFICE USE ONLY

Primary

Coverage Amount _____% up to _____ max _____ ded

Secondary

Coverage Amount _____% up to _____ max _____ ded

Please complete the Dental and Medical History on the back page. Thank you!

In your words, what is the orthodontic problem? _____

Have you had any previous orthodontic treatment or consultation? ❑ Yes ❑ No

If so, what work was completed, and by whom? _____

Has any other family member had orthodontics? _____

If so, what work was completed and by whom? _____

Were the results acceptable? ❑ Yes ❑ No

Do you now have or have you ever experienced pain or discomfort in your jaw joint? ❑ Yes ❑ No

Do you grind your teeth? ❑ Yes ❑ No

Do you have any speech problems? ❑ Yes ❑ No

Do you have or have you ever had any thumb of finger sucking habits? ❑ Yes ❑ No

Do you usually breath through your mouth while awake? ❑ Yes ❑ No

Have you ever experienced an adverse reaction during a medical or dental procedure? ❑ Yes ❑ No

Have you ever received serious trauma or injury to the teeth, face, jaws, or head? ❑ Yes ❑ No

Will you best describe the patients attitude toward orthodontic treatment:

❑ Wants treatment ❑ Treatment is necessary ❑ Unwilling, but agrees ❑ Uncooperative

MEDICAL HISTORY

Do you have, or have you ever had: ❑ Diabetes ❑ Heart Murmur ❑ Artificial joints or heart valves

Are you under the care of a physician for a specific condition? ❑ Yes ❑ No

If yes, please describe _____

Are you taking any medications? ❑ Yes ❑ No

If yes, please list _____

Please check if you had any of the following:

❑ AIDS/HIV Positive
❑ Allergies
❑ Asthma or Hayfever
❑ Blood Pressure Problems
❑ Convulsions or Epilepsy
❑ Difficulty Breathing
❑ Endocrine or Growth Problems
❑ Headaches
❑ Hepatitus
❑ Rheumatic/Scarlet Fever
❑ Tonsilitis
❑ Tuberculosis

AUTHORIZATION

I understand and acknowledge that I am financially responsible for the service provided for myself or the above named, regardless of insurance coverage. Treatment plans involving extended credit circumstances may have a credit check done on my credit rating. I also understand that the treatment estimate presented to me is only an estimate.

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the orthodontist to help determine appropriate and helpful orthodontic treatment. If there is any change in my dental or medical status, I will inform Dr. John.

Signature_____ Date_____