smileLOGIC ORTHODONTICS

Patient name: _____ Birthdate: _____

Welcome to Smile Logic Orthodontics! The following questions are designed to obtain your health history and help customize treatment so that you get the results you are looking for. We will confirm this information at your first visit.

Health Information

Does the patient have or has the patient ever had any of the following?

- ☐ Hospitalization / Surgery
- ☐ Heart Trouble
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ STI / AIDS
- ☐ Hepatitis / Jaundice
- ☐ Asthma / Hay Fever
- ☐ Fainting Spells / Seizures
- ☐ Arthritis
- ☐ Radiation treatment
- ☐ Stomach Ulcer
- ☐ Thumb / Finger Sucking
- ☐ Mouth Breathing / Snoring

- ○ Yes ○ No Is the patient in good health?
- ○ Yes ○ No Is the patient pregnant?
- ○ Yes ○ No Is the patient presently under the care of a physician for an illness or disease?
- ○ Yes ○ No Is the patient taking any medications?
- ○ Yes ○ No Does the patient require antibiotics prior to treatment?
- ○ Yes ○ No Does the patient have a bleeding tendency or do wounds heal slowly?
- ○ Yes ○ No Has there ever been trauma to the patient's face or teeth?
- ○ Yes ○ No Is the patient allergic to foods, nickel, latex or any drugs or medications?

Notes: _____

Responsible party name: _____ Phone: _____

Address: _____

I certify that I have read and understand this form and that the information given on this form is accurate. I understand the importance of a truthful health history and that my doctor and his staff will rely on this information for treating me. I will not hold my doctor, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____ Relationship to patient: _____

My main concerns are: _____

Check all statements below that apply to the patient:

The Teeth

- ☐ There are spaces between the teeth that I do not like.
- ☐ The teeth are overly crowded and rotated.
- ☐ The teeth stick out too far.
- ☐ The mouth seems too small, not enough room for the teeth.
- ☐ The teeth are coming in the wrong places.
- ☐ Not aware of any problems.

The Bite

- ☐ The bite is comfortable and I can eat what I want with no difficulties.
- ☐ I feel there is a problem with the bite or I have been told there is a problem.
- ☐ I clench my teeth during the day or grind my teeth during the night.
- ☐ I have frequent or chronic pain in my jaws, face or head.
- ☐ My jaws click, pop, or lock when I open my mouth.
- ☐ I have difficulty opening and/or closing my jaws.

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Check all statements below that apply to the patient:

The Primary Care Dentist

- ☐ I visit my primary care dentist regularly, at least every _____ months.
- ☐ My last cleaning was in the month of _____.
- ☐ My primary care dentist is _____ in _____(city).
- ☐ I have no dental problems that I am aware of other than misaligned teeth.
- ☐ I am aware of other dental problems that need attention.

The Orthodontist

- ☐ This is the patient's first experience with an orthodontic specialist.
- ☐ The patient has worn braces before.
- ☐ Someone in the family wore braces for _____ years at _____ (practice name).
  Were any teeth removed? ◯ Y ◯ N Were they happy with treatment? ◯ Y ◯ N
- ☐ I have seen another Orthodontist at _____ (practice name) and I would like a second opinion.
  Was treatment recommended? ◯ Y ◯ N Extractions? ◯ Y ◯ N Headgear? ◯ Y ◯ N

What I Expect from Orthodontic Treatment

- ☐ I want to find out if any treatment is needed.
- ☐ I only want the upper teeth straightened and aligned.
- ☐ I want the upper and lower teeth straightened and aligned.
- ☐ I want all the teeth straightened and the bite corrected if possible.

How Much Time Are You Willing to Commit to Orthodontic Treatment?

- ☐ I am willing to commit as much time and resources as required, even if surgery is needed, to get the best cosmetic and functional results.
- ☐ I want the best result that can be obtained without any facial surgery.
- ☐ I want to spend as little time as possible and am willing to accept compromises.

Insurance and Payment Options

- ☐ I have insurance from _____ (provider) that may pay for a portion of the treatment costs.
  Primary Insured Name _____ DOB _____ ID / SSN _____
- ☐ I have no insurance that covers orthodontic treatment.
- ☐ I am interested in saving the most money by paying for the total treatment at the beginning.
- ☐ I would rather have a payment plan with an initial deposit and monthly installments.

How Soon Would You Like to Get Started?

- ☐ I would like to get started as soon as possible if it is determined that treatment is indicated.
  Has the patient ever had impressions? ◯ Y ◯ N
- ☐ I want to meet with the Orthodontist to discuss the results of the diagnosis before making a decision.
- ☐ I want to discuss the findings with my spouse before making a decision to start treatment.
- ☐ I want to delay treatment as long as possible.

Care at Smile Logic Orthodontics

When making the decision to begin treatment, patients choose to begin with us for a variety of reasons.
To what extent are the following qualities important to you?

	Very Important	Somewhat Important	Not Important
Friendly staff and doctor	◯	◯	◯
Treatment comfort	◯	◯	◯
Treatment speed	◯	◯	◯
Treatment affordability	◯	◯	◯
Treatment result	◯	◯	◯

Other: _____

Who May We Thank for Referring You to Our Office? _____