

Welcome to Dr. Pearson's Office!

The benefits of a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset. Please fill out this form completely. The better we communicate, the better we can are for you.

About You

Today's date: _____ Email address: _____

Name: (Last, first, middle) _____

Circle one: Mr. Mrs. Ms. Dr.

I prefer to be called: _____ Circle one: Male Female

Birthdate: _____ Age: _____ SS #: _____

Home address: _____

Circle one: Single Married Divorced Widowed Separated

Home phone #: _____

Work phone #: _____

Cell/pager #: _____

Employer: _____

Employer's address: _____

How long there? _____ Occupation: _____

When & where are the best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

General dentist: _____

Last visit date: _____

Spouse Information

His/her name: _____

Employer: _____

Work phone #: _____

Birthdate: _____ SS#: _____

Primary Orthodontic Insurance

Orthodontic Coverage: (circle one) Yes No Dental Coverage: (circle one) Yes No

Insurance co. name: _____

Insurance co. address: _____

Insurance co. phone #: _____

Group # (Plan, local, or policy #): _____

Insured's name: _____ Relation: _____

Insured's birthdate: _____ Insured's SS#: _____

Insured's employer: _____

Secondary Orthodontic Insurance

Orthodontic Coverage: (circle one) Yes No Dental Coverage: (circle one) Yes No

Insurance co. name: _____

Insurance co. address: _____

Insurance co. phone #: _____

Group # (Plan, local, or policy #): _____

Insured's name: _____ Relation: _____

Insured's birthdate: _____ Insured's SS#: _____

Insured's employer: _____

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

His/her name: _____ Relation: _____

Work phone #: _____ Home phone #: _____

Medical History

Physician's name: _____

Phone #: _____ Date of last visit: _____

Your current physical health is: (circle one) Good Fair Poor

Are you currently under the care of a physician? (circle one) Yes No

Please explain: _____

Are you taking any prescription/over-the-counter drugs? (circle one) Yes No

Please list each one: _____

For women: Are you taking birth control pills? (circle one) Yes No

Are you pregnant? (circle one) Yes No Week #:

Are you nursing? (circle one) Yes No

Have you ever had any of the following diseases or medical problems? (Please circle all that apply)

- | | |
|--------------------------------|-----------------------------|
| Abnormal bleeding | Hemophilia |
| Anemia | Hepatitis |
| Artificial bones/joints/valves | High/low blood pressure |
| Asthma/Arthritis | HIV+/Aids |
| Blood transfusion | Hospitalized for any reason |
| Cancer/chemotherapy | Kidney problems |
| Congenital heart defect | Mitral valve prolapse |
| Diabetes | Psychiatric problems |
| Difficulty breathing | Radiation treatment |
| Drug/alcohol abuse | Rheumatic/Scarlet fever |
| Emphysema | Severe/frequent headaches |
| Epilepsy/seizures/fainting | Shingles |
| Fever blisters/herpes | Sickle cell disease/traits |
| Glaucoma | Sinus problems |
| Heart attack/stroke | Tuberculosis (TB) |
| Heart murmur | Ulcers/Colitis |
| Heart surgery/pacemaker | Venereal disease |

Please list any other serious medical condition(s) that you have had: _____

Are you allergic to any of the following: (circle all that apply)

- | | | |
|---------------------|--------------------|--------------|
| Aspirin | Dental anesthetics | Penicillin |
| Any metals/plastics | Erythromycin | Tetracycline |
| Codeine | Latex | Other |

Please list any other drugs/materials that you are allergic to: _____

Dental History

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

- | | | |
|---|-----|----|
| Have you ever had or been evaluated for orthodontic treatment? (circle one) | Yes | No |
| Have you ever had a serious/difficult problem associated with any previous dental work? | Yes | No |
| Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? | Yes | No |

