BLUESTONE ORTHODONTICS

Date _____

Welcome to our Practice!

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can and bring it to your appointment. We look forward to providing you with excellent orthodontic care.

PATIENT INFORMATION

Name: _____ Preferred Name: _____

Street Address: _____ City, State, Zip: _____

Cell Phone: _____ Birth date: _____ Gender: _____

Email Address: _____ Hobbies/Interests: _____

Spouse's Name: _____ Work Phone: _____

Who is responsible for this account? _____ Relationship: _____

Any family members treated here? If so, please name: _____

Whom may we thank for referring you to our office? _____

Emergency contact not living with you: _____ Phone number: _____ Relationship: _____

Dentist Name: _____ Approximate date of last visit?_____

MEDICAL HISTORY

Have you ever had any of the following? (Check all that apply)

□ Heart Murmur	□ Epilepsy	□ Special Diet
□ High Blood Pressure	□ Swollen Neck Glands	□ Rheumatic Fever
□ Headaches	□ Low Blood Pressure	□ Sinus Problems
□ Hepatitis, Jaundice or Liver Disease	□ Circulatory Problems	□ Cancer
□ Nervous Problems	□ Psychiatric Care	□ AID/HIV
□ Radiation Treatment	□ Mitral Valve Prolapse	□ Thyroid Disease
□ Recent Weight Loss	□ Allergies to Medicine or Drugs	□ Ulcer
□ Back Problems	□ General Allergies	□ Diabetes
□ Blood Disease	□ Chemical Dependency	□ Hemophilia
□ Respiratory Disease	□ Arthritis	

Please fill out additional medical information and insurance information on the back.

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MEDICAL HISTORY

(Continued)

Do you have any drug allergies or ever had an adverse reaction to any medication? _____

If so, to what? _____

Have you ever responded adversely to medical or dental treatment? If yes explain. _____

_____

Are you taking any medication at this time? If so what? _____

Are you under the care of a physician? If yes for what condition? _____

(***Female Patient***) Are you or do you suspect that you might be pregnant? _____ Yes _____ No
(**This information is requested in the event we need to take an x ray**)

Is there anything else we should know about your medical history? _____

EMPLOYMENT AND INSURANCE INFORMATION

Patient Employed By: _____ Occupation: _____

Business Address: _____ Business Phone: _____

City, State, Zip: _____

Name of Dental Insurance Company: _____

Name of Insurer: _____

Street Address: _____

City, State, Zip: _____

Phone number: _____

Insurance Plan ID #: _____

Group #: _____

Insurer's Birth date: _____

Social Security #: _____

Signature _____ Date: _____