www.webuildsmileappeal.com

For Adults: Welcome to Our Practice

SMILE APPEAL ORTHODONTICS
MARK L. YOUNGKER, DDS, MS

1. ABOUT YOU

Today's Date: ________________ ☐ Mr. ☐ Ms. ☐ Mrs.

Name: Age: ________________

____
FIRST M.I. LAST

I prefer to be called: ____________________ ☐ Male ☐ Female

Home/Cell Ph #: ________________________________

Work Ph #: ________________________________

Email: ________________________________

DOB: ________________ Soc. Sec. #: ________________

Driver's License #: ________________________________

Home Address:

____
APT #

____
CITY STATE ZIP

2. ABOUT YOUR EMPLOYER

Name: ________________________________

Address: ________________________________
APT #

____
CITY STATE ZIP

How long have you worked there? ________________

Occupation: ________________________________

When and where are the best times to reach you?

____

Other family members seen by us: ________________

Whom may we thank for referring you?

____

3. SPOUSE INFORMATION

Name: ________________________________

Employer: ________________________________

Work Ph #: ________________________________

Driver's License #: ________________________________

S.S. #: ________________ DOB: ________________

DENTAL INFORMATION

Previous/Present Dentist: ________________________________

Street: ________________________________

Ph #: ________________________________

Last Visit: ________________________________

4. RESPONSIBLE PARTY INFO

Name: ________________________________

Billing Address: ________________________________

____
CITY STATE ZIP

Work Ph #: ________________ Ext.: ________

Home/Cell Ph#: ________________________________

Email: ________________________________

Employer: ________________________________

Driver's License #: ________________________________

S.S. #: ________________________________

EMERGENCY CONTACT

Name: ________________________________

Home/Cell Ph #: ________________________________

5. PRIMARY DENTAL INSURANCE

Insurance Name: ________________________________

Insurance Address:

____
APT #

____
CITY STATE ZIP

Insurance Co. Ph #: ________________________________

Group/Policy #: ________________________________

Insured's Name: ________________________________

Relationship to Patient: ________________________________

Insured's DOB: ________________________________

Insured's Employer: ________________________________

S.S. #: ________________________________

Orthodontic Coverage: ☐ Yes ☐ No

SECONDARY DENTAL INSURANCE

Insurance Name: ________________________________

Insurance Address:

____
APT #

____
CITY STATE ZIP

Insurance Co. Ph #: ________________________________

Group/Policy #: ________________________________

Insured's Name: ________________________________

Relationship to Patient: ________________________________

Insured's DOB: ________________________________

Insured's Employer: ________________________________

S.S. #: ________________________________

Orthodontic Coverage: ☐ Yes ☐ No

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For Adults: Health History

6. DENTAL HISTORY

Why have you come to the orthodontist today?

____

- Are you currently in pain? ☐ Yes ☐ No
- Your current dental health is ☐ GOOD ☐ FAIR ☐ POOR
- Have you ever had a serious/difficult problem associated with previous dental work? ☐ Yes ☐ No
- Have you ever had any pain or tenderness in the jaw joint (TMJ/TMD)? ☐ Yes ☐ No
- Do you like your smile? ☐ Yes ☐ No
- Do your gums ever bleed? ☐ Yes ☐ No
- How many times a week do you floss? ____________
- How many times a day do you brush? ____________
- Types of bristles? ☐ HARD ☐ MEDIUM ☐ SOFT

7. MEDICAL HISTORY

- Do you have a personal physician? ☐ Yes ☐ No

Name: ______________________________

Ph #: ______________ Last Visit: ______________

- Your current physical health is ☐ GOOD ☐ FAIR ☐ POOR
- Are you currently under the care of a doctor? ☐ Yes ☐ No

Explain: ______________________________

- Are you taking any prescription drugs? ☐ Yes ☐ No

Please list: ______________________________

____

FOR WOMEN ONLY

- Are you taking birth control pills? ☐ Yes ☐ No
- Are you pregnant? **Week #:** ____________ ☐ Yes ☐ No
- Are you nursing? ☐ Yes ☐ No

8. Have you ever had any of the following diseases or medical problems?

YES/NO		YES/NO	
☐ ☐	Prosthesis	☐ ☐	History of Scarlet Fever
☐ ☐	Heart Attack	☐ ☐	Congenital Heart Defects
☐ ☐	Cancer	☐ ☐	Convulsions/Epilepsy
☐ ☐	Diabetes	☐ ☐	Abnormal Bleeding
☐ ☐	Rheumatic Fever	☐ ☐	Artificial Valves
☐ ☐	HIV+/AIDS	☐ ☐	Heart Surgery/Pacemaker
☐ ☐	Hemophilia	☐ ☐	Any Stays in Hospital
☐ ☐	Asthma	☐ ☐	Kidney/Liver Problems
☐ ☐	Hepatitis	☐ ☐	Mitral Valve Prolapse
☐ ☐	Tuberculosis	☐ ☐	Artificial Bones/Joints
☐ ☐	Shingles	☐ ☐	Severe/Frequent Headaches
☐ ☐	Fever Blister	☐ ☐	High/Low Blood Pressure
☐ ☐	Venereal Disease	☐ ☐	Drug/Alcohol Abuse
☐ ☐	Ulcers/Colitis	☐ ☐	Blood Transfusion
☐ ☐	Heart Murmur	☐ ☐	Anemia/Radiation Treatment
☐ ☐	Emphysema	☐ ☐	Glaucoma
☐ ☐	Sinus Problems	☐ ☐	Difficulty Breathing

Other: ______________________________

Are you allergic to any of the following?

☐ ☐	Aspirin	☐ ☐	Dental Anesthetics
☐ ☐	Codeine	☐ ☐	Tetracycline
☐ ☐	Latex	Other:	____________
☐ ☐	Penicillin		____________
☐ ☐	Erythromycin		____________

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

9. I certify that the information that I have given is correct to the best of my knowledge, and I understand that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I also authorize the dental staff to perform the necessary dental services I may need during treatment.

____

Signature of Parent/Guardian Date

Payment is due in full at time of treatment unless prior arrangements have been approved.

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Initials: ______________ Date: ____________

Doctor Comments: ______________________________

____

____

Medical History Update:

1. Date: ____________ Signature: ____________

Comments: ______________________________

2. Date: ____________ Signature: ____________

Comments: ______________________________

____