TEGUIS ORTHODONTICS
HAPPY SMILES ◇ HAPPY PEOPLE

WELCOME TO OUR OFFICE

Patient's Full Legal Name: _____ Date of Birth: _____

Preferred Name: _____ Sex at birth: ☐ Male ☐ Female Age: _____

What are your pronouns? (Check all that apply.)

☐ She/her/hers ☐ He/him/his ☐ They/them/theirs ☐ Other: _____

Hobbies / Interests: _____

Mailing Address: _____City: _____State: _____Zip: _____

Mobile Phone Number: _____ Other Phone Number: _____

Email Address: _____

Dentist: _____ Physician: _____

Siblings Names and Ages: _____

What is the primary reason for your visit? _____

Why did you select our office for treatment? _____

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

RESPONSIBLE PARTY INFORMATION

Full Name: _____ Relationship: _____

Your Phone Number: _____ Email: _____

Mailing Address: _____City: _____State: _____Zip: _____

Employer: _____ Work phone: _____

Full Name: _____ Relationship: _____

Your Phone Number: _____ Email: _____

Mailing Address: _____City: _____State: _____Zip: _____

Employer: _____ Work phone: _____

Orthodontic Insurance Coverage(s) Check all that apply.

- o Insurance coverage for Orthodontic treatment
- o Insurance coverage for dental treatment
- o Maine Care
- o Healthy Kids of New Hampshire

PATIENT MEDICAL AND DENTAL HISTORY

List any allergies (aspirin, Advil, ibuprofen, latex, acrylic, nickel metals, foods, medications): _____

_____

_____

List any medications that you are currently taking, how long and for what: _____

_____

_____

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Check any that apply:

- o Arthritis
- o Allergies
- o Asthma
- o Lung problems
- o Tuberculosis
- o Skin problem
- o Canker/cold sores
- o Hepatitis
- o Hypoglycemia
- o Epilepsy
- o Fainting spells
- o Parkinson's
- o Learning Disability
- o Cerebral Palsy
- o Multiple Sclerosis
- o Hyperactivity
- o Downs Syndrome
- o Heart condition
- o Rheumatic fever
- o Scarlet fever
- o Ear problems
- o Cancer
- o Radiation Treatment
- o Bruise or Bleed Easily
- o Birth trauma
- o Pregnancy
- o Kidney problems
- o Chest pain
- o Diabetes
- o Swallowing difficulties
- o Stroke
- o Mononucleosis
- o Hearing problems
- o High blood pressure
- o Venereal disease
- o Allergies

If you have checked of any of the items above, please describe: _____

_____

_____

Check any that apply:

- o Permanent or supernumerary (extra) teeth removed
- o Chipped or injured any teeth
- o Mouth breathing (breathing mainly through mouth & not nose)
- o Thumb/Finger sucking
- o Grinding or clenching teeth
- o Jaw pain or clicking
- o Use fluoride mouth rinse
- o Bleeding gums
- o Frequent decay
- o Head or backaches
- o Dental or Medical x-rays in the last six months
- o Injuries to mouth, head, neck or teeth

If you checked any of the items above, please describe: _____

_____

_____

I have read and understand the above questions. If there are any changes later to this medical / dental status, I will inform Teguis Orthodontics.

Signature: _____ Date: _____

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INSURANCE QUESTIONNAIRE

Name and Address of Dental Insurance:

_____

_____

_____

_____

Insurance Company's Phone Number: _____

Name of Policy Holder: _____

Policy Holder's Date of Birth: _____

Policy Holder's Social Security Number: _____

Policy Holder's Employer: _____

Policy ID: _____

Group ID: _____

The above information is current. If there are any changes to dental insurance, I will inform Teguis Orthodontics promptly.

_____

Patient/Caregiver Signature Date