Keith Street, D.M.D.
Orthodontics
Dentofacial Orthopedics

We would like to welcome you to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible.

Thank You!

PATIENT INFORMATION

Patient Name _____ ❑ Male ❑ Female
Social Security # _____ Birth Date _____ Driver License # _____
Home Address _____
City _____ State _____ Zip _____
Primary Phone # _____ ❑ home ❑ cell Ok to leave Message? ❑ Y ❑ N
Secondary Phone # _____ ❑ home ❑ cell ❑ other Ok to leave Message? ❑ Y ❑ N
Email _____
Employer's Name _____ Occupation _____

SPOUSE / EMERGENCY CONTACT INFORMATION

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Significant Other

Spouse / Partner's Name _____
Emergency Contact Name _____
Phone # _____ Relation to you _____
Address _____
City _____ State _____ Zip _____

Person(s) OK to release appointment or medically related information to concerning you.
_____ Relation(s) _____

INSURANCE INFORMATION

Primary Insurance Company _____ Phone Number _____
Group # _____ Policy # _____ Member ID # _____
Policy Holder's Name _____ Relation _____
Policy Holder's Social Security # _____ Policy Holder's Birth Date _____
Employer _____ Work Phone # _____
Co-pay (if known) _____ Deductible (if known) _____

Secondary Insurance Company _____ Phone Number _____
Group # _____ Policy # _____ Member ID # _____
Policy Holder's Name _____ Relation _____
Policy Holder's Social Security # _____ Policy Holder's Birth Date _____
Employer _____ Work Phone # _____
Co-pay (if known) _____ Deductible (if known) _____

DENTAL HISTORY

General Dentist _____ Last Visit _____

How did you hear about our Practice?

❑ Ad ❑ Internet ❑ Family or Friend ❑ Physician ❑ Other

Name of person referring (if applicable) _____

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

_____

Have you visited an orthodontist before? ❑ Y ❑ N

When? _____ Reason? _____

Have your tonsils or adenoids been removed? ❑ Y ❑ N

Have you ever experienced jaw joint pain/discomfort (TMJ/TMD) ? ❑ Y ❑ N

Do you have any missing or extra permanent teeth? ❑ Y ❑ N

Have you ever had an injury to (*select all that apply*): ❑ Teeth ❑ Mouth ❑ Chin

Do you have speech problems? ❑ Y ❑ N If so, explain _____

Do your gums bleed? ❑ Y ❑ N Do you smoke? ❑ Y ❑ N

Do you like your smile? ❑ Y ❑ N

Do you currently or have you ever had any of the following habits

(*check all that apply*)

❑ Clenching/Grinding Teeth ❑ Mouth Breathing ❑ Thumb / Finger Sucking

❑ Lip Sucking/Biting ❑ Nail biting ❑ Chewing / Eating Problem

MEDICAL HISTORY

Are you currently being treated by a physician? ❑ Y ❑ N Reason _____

Physician _____ Last Visit _____ Phone _____

Do you have any allergies/sensitivities to medications or latex? ❑ Y ❑ N

If yes, please list allergies.

_____

Are you currently taking any prescription or over-the-counter medications? ❑ Y ❑ N

Please list, with dosage. _____

Have you ever taken any of the group of drugs collectively referred to as “fen-phen?” These include combinations of lonimin, Apidex, Fastin (brand names of Phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine)? ❑ Y ❑ N

Have you had any serious illnesses or operations? If yes, describe:

_____

Have you ever had a blood transfusion? ❑ Y ❑ N

If yes, give approximate dates: _____

(Women)

Are you pregnant? ❑ Y ❑ N Nursing? ❑ Y ❑ N Taking birth control pills? ❑ Y ❑ N

Check if you have or have ever had any of the following:

❑ Anemia	❑ Cortisone Treatments	❑ Hepatitis	❑ Scarlet Fever
❑ Arthritis, Rheumatism	❑ Cough, Persistent	❑ High Blood Pressure	❑ Shortness of Breath
❑ Artificial Heart Valves	❑ Coughing Blood	❑ HIV/AIDS	❑ Skin Rash
❑ Artificial Joints	❑ Diabetes	❑ Jaw Pain	❑ Stroke
❑ Asthma	❑ Epilepsy	❑ Kidney Disease	❑ Swelling of Feet or Ankles
❑ Back Problems	❑ Fainting	❑ Liver Disease	❑ Thyroid Problems
❑ Blood Disease	❑ Glaucoma	❑ Mitral Valve Prolapse	❑ Tobacco Habit
❑ Cancer	❑ Headaches	❑ Pacemaker	❑ Tonsillitis
❑ Chemical Dependency	❑ Heart Murmur	❑ Radiation Treatment	❑ Tuberculosis
❑ Chemotherapy	❑ Heart Problems	❑ Respiratory Disease	❑ Ulcer
❑ Circulatory Problems	❑ Hemophilia	❑ Rheumatic Fever	❑ Venereal Disease

AUTHORIZATION

- I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my medical status.
- I hereby authorize the release of any information pertaining to my medical treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payment of any benefits to the office. I understand that I am responsible for any amount not covered by insurance.
- I understand that where appropriate, credit bureau reports may be obtained.

_____ _____

Patient Signature and/or Responsible Party Date