ADVANCED ORTHODONTICS OF WISCONSIN

Patient Biographical Information

*First Name:	*Last Name:
Middle Initial:	*Marital Status:
*Gender:	*Birth Date: / /
*Address:	*Patient Phone:
*City:	Work Phone:
*State:	*Zip Code:
Patient Cell: Reminder: Y N	Email: Reminder: Y N
How did you hear about us?:	*Dentist:
We confirm appointments using email and text messaging.	

Financial Party or Account Access Information:

IF THE PATIENT IS A MINOR, PLEASE PROVIDE RESPONSIBLE PARTY INFORMATION:

Responsible Party	
Name/Relationship:	Account Access (circle one): FULL NONE
Address:	Phone:
City:	Work Phone:
State:	Zip code:
Cell:	Email:
Name/Relationship:	Account Access (circle one): FULL NONE
Address:	Phone:
City:	Work Phone:
State:	Zip code:
Cell: Reminder: Y N	Email: Reminder: Y N

Patient Heath History: Your careful and complete answers to the following questions will be helpful in the preparation of an orthodontic program for you or your child. Only by knowing the many factors which can influence a problem is it possible for the orthodontist to recommend the most suitable and beneficial therapy. *REMINDER: Women who are pregnant, or think that they may be pregnant, must notify the assistant to avoid x-rays.*

DR G. ______________________________________

Current medications being taken:

Any History of:

YES / NO :Arthritis	YES / NO :Bone/Joint disease	YES / NO :Other illnesses
YES / NO :Auto Immune Diseases	YES / NO :Epilepsy/Convulsions	YES / NO :Blood Disease
YES / NO :Diabetes	YES / NO :Heart disease, Rheumatic fever	YES / NO :TMJ/Jaw Abnormalities
YES / NO :HIV/AIDS	YES / NO :Kidney trouble	YES / NO :Asthma, Allergies, Hay fever
YES / NO :High or low blood pressure	YES / NO : X-Ray exposure, extensive	YES / NO :Cancer
YES / NO :Liver problems	YES / NO :Gingivitis/Gum Disease	YES / NO :Hepatitis
YES / NO :Injury, tooth extraction, or missing teeth	YES / NO :Have you ever taken Bio phosphates? i.e. Fosamax, Boniva, etc…	YES / NO :Prolonged bleeding following extractions
If YES to any of the above, Please comment:		

YES / NO :Food Allergies	YES / NO :Thumb/Finger Habit	YES / NO :Good General Health
YES / NO :Major Operations	YES / NO :Injury to Face/Mouth/Teeth	YES / NO :Difficulty Chewing/Swallowing
YES / NO :Tonsils/Adenoids Removed	YES / NO : Are you Pregnant?	YES / NO :Puberty reached?
YES / NO :Previous orthodontic treatment	YES / NO :Difficulty breathing through nose	YES / NO :Boys – Voice Changed, Girls – Menstruation started?
If YES to any of the above, Please comment:		

Do you have Dental/Orthodontic Insurance? YES / NO If Yes, please complete the following:

Policy Holder:	Policy Holders DOB: / /	Relationship to Patient:
Insurance Company:	Subscriber #:	Group #:
Ins. Co. Phone #:	Ins. Co. Address:	Employer:
If you have dual coverage, please provide information on second insurance plan:		
Policy Holder:	Policy Holders DOB: / /	Relationship to Patient:
Insurance Company:	Subscriber #:	Group #:
Ins. Co. Phone #:	Ins. Co. Address:	Employer:

By providing your insurance information, you agree that we may share any information requested by your insurance provider for the purposes of your claim. You also authorize us to invoice your insurance and be paid directly by them.

I agree that the information provided on this form is accurate and completed fully to the best of my ability:

Person Completing this form (printed):	Signature:	Relationship to Patient:	Today's Date: