



Rasch

ORTHODONTICS

Growing confident smiles

PERSONAL INFORMATION

1. ABOUT YOU

Date

Patient Name _____ Date of Birth _____

Home Address _____

City, Zip _____

Cell No. _____

Home No. _____ Work No. _____ Ext. _____

May we contact you at this work phone? Yes No

Email address(es) _____

How would you prefer to be reminded of appointments? E-mail Text Message or Phone (indicate preferred number to call)

I prefer to be addressed as _____

(please check) Male Female Child Single Married Widowed Divorced Domestic Partnered

Employer _____

Occupation _____

If patient is a child indicate the following: Age: _____ Grade: _____

School: _____

Other family and household members at Rasch Orthodontics _____

Check all the ways you have heard about us

Previous Patient Rasch Orthodontics Website Insurance Website

Whom may we thank for referring you _____

Other _____

2. SPOUSE/EMERGENCY INFO

Spouse/Partner _____

Employer _____

Cell No. _____

Work No. _____ Ext. _____

Date of Birth _____

In the event of an emergency, is there someone other than a spouse you would like us to contact?

Name _____

Relation _____

Home No. _____

Cell No. _____

Work No. _____ Ext. _____

3. FINANCIAL INFO

If other than yourself, please list the person responsible for the account and their information below

Name _____

Billing Address _____

Home No. _____

Work No. _____ Ext. _____

Relationship to patient _____

Employer Name _____

4. INSURANCE INFO

Primary Dental Coverage Insurance Co. _____

Insured's Name _____

Date of Birth _____

Social Security No. _____

Note: Social Security No. is needed to verify insurance benefits.

Do you have Secondary Dental Insurance Coverage? _____

Yes No

I authorize release of any information relating to claims filed by **Rasch Orthodontics**.

Signature _____

I wish to assign benefits to **Rasch Orthodontics** and understand that I am responsible for any co-payment and deductibles that my insurance does not cover.

Signature _____ Date _____

DENTAL INFORMATION

1. MEETING PATIENT'S IMMEDIATE NEEDS

Patient Name _____

Have you had previous orthodontic treatment? Yes; Where: _____ When: _____ No

What is your main reason for seeking orthodontic treatment? _____

Do you like your smile? Yes No

Anything you would like to change if you could? Color Shape Position

Detail (if needed) _____

Have you ever had a serious/difficult problem associated with any previous dental work? Yes No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Yes No

Have you ever had an injury to your: Mouth Teeth Chin

Do you have any speech problems? Yes No

Do you generally breathe through your mouth? Awake Asleep

Do you have any missing or extra permanent teeth? Yes No

Do you clench or grind your teeth? Yes No

Do you suffer from frequent canker sores? Yes No

Do you have any oral habits? (thumb-sucking, nail-biting, pen-biting, etc.) Yes No

Do you have a history of gum disease or peridontitis? Yes No

Do you have problems with your teeth now? Yes No

If Yes (check) Hot Cold Sweet Food-Caught Broken Tooth Other

"If patient is a child, has he or she entered their pubertal growth spurt?" Yes No

2. DENTAL HISTORY

When was the last time you saw a dentist? 1st visit 6 mo. 1 yr. 2 yrs. 3+ yrs.

Dentist _____

Clinic-Location _____

Phone No. _____

Last Visit _____

What treatment did you receive? Preventive Basic Fillings Major Restoration

Did you have any treatment that was recommended but not yet completed? Yes No

If yes _____

Is there anything you don't like about dental appointments? Discomfort Fee Time Inconvenience

Afraid Other (explain) _____

3. HOME CARE & PERIO HISTORY

What do you do at home to take care of your oral health?

Brush; How often _____ Floss; How often _____ Mouthwash Yes No

Any bleeding when you brush or floss your teeth? Yes No

Other (explain) _____





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HEALTH INFORMATION

1. HEALTH HISTORY

Today's Date _____

Patient Name _____

Patient Date of Birth _____

Personal Physician _____

Clinic-Location _____

Phone No. _____

Please list any medications you are currently taking (include over the counter medicines)

Medications _____

Reasons _____

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you currently taking birth control pills? Yes No

Have you ever taken osteoporosis treatment drugs? Yes No

2. ALLERGIES

Please circle if you have any allergies or adverse reactions to the following:

Amoxicillin

Aspirin

Erythromycin

Metals / Jewelry

Sulfa

Anesthetics

Codeine

Latex

Penicillin

Tetracycline

Other (explain) _____

(If any circled) please describe symptoms: _____

3. CONDITIONS

Please circle if you have ever had any of the following diseases or medical conditions.

- Alzheimer's / Memory Loss
- Anemia
- Anorexia / Bulimia
- Arthritis
- Artificial Joints (Date _____)
- Artificial Heart Valves
- Asthma / Hay Fever
- Blood Transfusions
- Cancer / Chemotherapy
- Cold Sores / Herpes
- Congenital Heart Defect
- Diabetes
- Difficulty Breathing
- Drug / Alcohol Abuse
- Emphysema
- Epilepsy / Seizures / Fainting
- Gastrointestinal Disorder / Acid Reflux
- Glaucoma (Narrow Angle, Growth, Swelling in Mouth)
- Headaches (Severe, Frequent)
- Hearing Impaired
- Heart Attack
- Heart Murmur
- Heart Surgery
- Hemophilia / Abnormal Bleeding
- Hepatitis A B C D
- High / Low Blood Pressure
- HIV / AIDS
- Liver Disease
- Kidney Problems
- Migraines
- Mitral Valve Prolapse
- Pacemaker
- Radiation Treatments
- Rheumatic / Scarlet Fever
- Shingles
- Smoking / Tobacco
- Sinus Problems
- Stents Placed in Heart (Date _____)
- Stroke
- Snoring / Sleep Apnea
- Thyroid problems
- Tuberculosis
- Tumor Growth
- Venereal Disease
- Other / Surgeries

Have you ever been told you need antibiotics before a dentist appointment? Yes No

Are you pregnant? Yes No

Are you currently nursing? Yes No

Would you like to speak privately with the Doctor about any problems? Yes No

I hereby certify that the information I have given here today is correct to the best of my knowledge and that payment is due in full at the time of treatment unless prior arrangements have been approved. Furthermore I understand that a 24 hour notice is required to change appointments.

Signature _____

Date _____



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HEALTH INFORMATION

[FOR RASCH ORTHODONTIC STAFF TO UPDATE]

Date	Changes	No Change	Patient Initials

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Signature

Date