Rasch
ORTHODONTICS
Growing confident smiles

PERSONAL INFORMATION

1. ABOUT YOU

Date

Patient Name Nickname:

Date of Birth

Home Address

City, State, Zip

Home #

Cell #

Cell Phone Provider:

Work # Ext.

May we contact you at this work phone? ☐ Yes ☐ No

E-mail address

How would you prefer to be reminded of appointments?
☐ E-mail ☐ Text Message ☐ Home Phone ☐ Cell Phone ☐ Work Phone

Occupation

Employer

If patient is a child please indicate the following

School Grade

Other family members at Rasch Orthodontics

Please check all the ways you have heard about us

☐ Rasch Orthodontics Website ☐ Insurance Website ☐ Another Patient
☐ Whom may we thank for referring you

☐ Other

2. EMERGENCY INFORMATION

In the event of an emergency, who would you like us to contact?

Primary Em. Contact

Relationship to Patient

Home #

Cell #

Work # Ext.

Secondary Em. Contact

Relationship to Patient

Home #

Cell #

Work # Ext.

3. FINANCIAL INFORMATION

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

Name

Relationship to patient

Billing Address

City, State, Zip

Home #

Cell #

Work # Ext.

4. INSURANCE INFO

Do you have Primary Dental Insurance Coverage?

☐ Yes ☐ No

Primary Dental Insurance Co.

Subscriber Name

Date of Birth

Employer

Group Name

Group Number

Subscriber/Member ID

Do you have Secondary Dental Insurance Coverage?

☐ Yes ☐ No

Secondary Dental Insurance Co.

Subscriber Name

Date of Birth

Employer

Group Name

Group Number

Subscriber ID

I hereby certify that the information I have given above is correct to the best of my knowledge. I authorize the release of any information relating to claims filed by Rasch Orthodontics.

Signature Date

DENTAL INFORMATION

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1. MEETING PATIENT'S IMMEDIATE NEEDS

Patient Name

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

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 ☐ Other (explain)

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

If yes, please explain

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

If yes, please explain

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

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

Do you experience any of the following problems with your teeth? ☐ Yes ☐ No

☐ Hot ☐ Cold ☐ Sweet ☐ Food-Caught ☐ Other

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

Do you clench or grind your teeth? ☐ No ☐ Awake ☐ Asleep

Do you have any speech problems? ☐ Yes ☐ No

Do you generally breathe through your mouth? ☐ Yes ☐ No

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

Do you smoke or use tobacco products? ☐ Yes ☐ No

If patient is a child, has he/she entered their growth spurt? ☐ Yes ☐ No

2. 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 (please explain)

3. DENTAL HISTORY

Dentist

Date of 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, please explain

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Signature Date

HEALTH INFORMATION

1. HEALTH HISTORY

Patient Name

Personal Physician

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

Medications	Reasons

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. CERTIFICATION

I have read and understand the questions on this form and the previous forms. I hereby certify that the information I have given today is correct to the best of my knowledge. I understand that Rasch Orthodontics is not responsible for any errors or omissions that I have made upon completing these forms. I further understand that it is my responsibility to inform Rasch Orthodontics about any changes in my personal information, dental status, and medical status.

Signature Date

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