



Rasch

ORTHODONTICS

Growing confident smiles

PERSONAL INFORMATION

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. _____

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 _____

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 _____



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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