

Thank you for providing this important information to help us serve you best. If you have any questions or need assistance, just ask. We're happy to help!



GARDENDALE 305 MITCHELL HILL RD. | GARDENDALE, AL 35071 · (205) 631-6033
ALABASTER 100 SOUTH COLONIAL DR. SUITE 800 | ALABASTER, AL 35007 · (205) 621-1111

Patient Information

NAME _____ PREFERRED NAME _____
DATE OF BIRTH _____ GENDER _____
HOME PHONE _____ CELL PHONE _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____ EMAIL _____
EMPLOYER _____ OCCUPATION _____
EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____
WORK PHONE _____ NUMBER OF YEARS EMPLOYED _____
HAVE WE TREATED ANY FAMILY MEMBERS? IF YES, WHO? _____
WHOM MAY WE THANK FOR REFERRING YOU? _____
MARITAL STATUS MARRIED DOMESTIC PARTNERSHIP SEPARATED DIVORCED WIDOWED SINGLE

Spouse/Partner Information

(IF APPLICABLE)

NAME _____ DATE OF BIRTH _____
EMPLOYER _____ OCCUPATION _____
EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____
WORK PHONE _____ NUMBER OF YEARS EMPLOYED _____
CELL PHONE _____ EMAIL _____

Primary Insurance Information

CHECK HERE IF NO ORTHODONTIC COVERAGE WILL BE APPLIED

INSURANCE COMPANY _____ INSURANCE PHONE NUMBER _____
EMPLOYER/GROUP NAME _____ GROUP NUMBER _____
SUBSCRIBER/EMPLOYEE _____ SUBSCRIBER ID _____
DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

Secondary Insurance Information

CHECK HERE IF NO SECONDARY INSURANCE

INSURANCE COMPANY _____ INSURANCE PHONE NUMBER _____
EMPLOYER/GROUP NAME _____ GROUP NUMBER _____
SUBSCRIBER/EMPLOYEE _____ SUBSCRIBER ID _____
DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

Emergency Contact Information

NAME _____ RELATIONSHIP TO PATIENT _____
HOME PHONE _____ CELL PHONE _____

Please take a moment to complete the reverse side of this form.

Medical History

PHYSICIAN _____ PHONE _____ DATE OF LAST EXAM _____

<p>1. ARE YOU UNDER MEDICAL TREATMENT NOW? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>2. HAVE YOU BEEN HOSPITALIZED FOR ANY SURGICAL OPERATIONS OR SERIOUS ILLNESS IN THE PAST FIVE YEARS? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>_____</p> <p>3. ARE YOU TAKING MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>IF YES, WHAT MEDICATION(S) ARE YOU TAKING?</p> <p>_____</p> <p>4. DO YOU USE TOBACCO? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>5. ARE YOU AWARE OF BEING ALLERGIC TO ANY MEDICATIONS OR SUBSTANCE, INCLUDING METALS? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>IF YES, WHAT?</p> <p>_____</p> <p>6. FEMALES ONLY: ARE YOU PREGNANT, OR THINK YOU MAY BE? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>7. HAVE YOU EVER BEEN EVALUATED FOR AIRWAY OBSTRUCTION AND/OR SLEEP APNEA? <input type="checkbox"/> Y <input type="checkbox"/> N</p>	<p>8. EVER TAKEN BISPHOSPHONATES (EX: FOSAMAX) FOR OSTEOPOROSIS? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>IF YES, SPECIFY _____</p> <p>9. PLEASE CHECK ALL THAT APPLY:</p> <table border="0"> <tr> <td>HAY FEVER/ALLERGIES</td> <td><input type="checkbox"/></td> <td>LEUKEMIA</td> <td><input type="checkbox"/></td> </tr> <tr> <td>COLD SORES</td> <td><input type="checkbox"/></td> <td>KIDNEY/LIVER DISEASE</td> <td><input type="checkbox"/></td> </tr> <tr> <td>MIGRAINES</td> <td><input type="checkbox"/></td> <td>ANEMIA</td> <td><input type="checkbox"/></td> </tr> <tr> <td>DIABETES/GLAUCOMA</td> <td><input type="checkbox"/></td> <td>CANCER</td> <td><input type="checkbox"/></td> </tr> <tr> <td>RHEUMATIC FEVER</td> <td><input type="checkbox"/></td> <td>JOINT REPLACEMENT/IMPLANT</td> <td><input type="checkbox"/></td> </tr> <tr> <td>AIDS OR HIV INFECTION</td> <td><input type="checkbox"/></td> <td>HEPATITIS/JAUNDICE</td> <td><input type="checkbox"/></td> </tr> <tr> <td>CARDIAC PACEMAKER</td> <td><input type="checkbox"/></td> <td>STOMACH TROUBLES/ULCERS</td> <td><input type="checkbox"/></td> </tr> <tr> <td>ASTHMA (INHALER)</td> <td><input type="checkbox"/></td> <td>SINUS PROBLEMS</td> <td><input type="checkbox"/></td> </tr> <tr> <td>FAINING/SEIZURES</td> <td><input type="checkbox"/></td> <td>STROKE</td> <td><input type="checkbox"/></td> </tr> <tr> <td>THYROID PROBLEM</td> <td><input type="checkbox"/></td> <td>RADIATION THERAPY</td> <td><input type="checkbox"/></td> </tr> <tr> <td>HIGH/LOW BLOOD PRESSURE</td> <td><input type="checkbox"/></td> <td>RESPIRATORY PROBLEMS</td> <td><input type="checkbox"/></td> </tr> <tr> <td>HEART TROUBLE</td> <td><input type="checkbox"/></td> <td>BONE DISORDER</td> <td><input type="checkbox"/></td> </tr> <tr> <td>EPILEPSY/CONVULSIONS</td> <td><input type="checkbox"/></td> <td>OSTEOPEMIA/OSTEOPOROSIS</td> <td><input type="checkbox"/></td> </tr> <tr> <td>TAKING MEDICATION:</td> <td><input type="checkbox"/></td> <td>REMOVAL OF ADENOIDS/TONSILS</td> <td><input type="checkbox"/></td> </tr> </table> <p>IF SO, SPECIFY: _____</p>	HAY FEVER/ALLERGIES	<input type="checkbox"/>	LEUKEMIA	<input type="checkbox"/>	COLD SORES	<input type="checkbox"/>	KIDNEY/LIVER DISEASE	<input type="checkbox"/>	MIGRAINES	<input type="checkbox"/>	ANEMIA	<input type="checkbox"/>	DIABETES/GLAUCOMA	<input type="checkbox"/>	CANCER	<input type="checkbox"/>	RHEUMATIC FEVER	<input type="checkbox"/>	JOINT REPLACEMENT/IMPLANT	<input type="checkbox"/>	AIDS OR HIV INFECTION	<input type="checkbox"/>	HEPATITIS/JAUNDICE	<input type="checkbox"/>	CARDIAC PACEMAKER	<input type="checkbox"/>	STOMACH TROUBLES/ULCERS	<input type="checkbox"/>	ASTHMA (INHALER)	<input type="checkbox"/>	SINUS PROBLEMS	<input type="checkbox"/>	FAINING/SEIZURES	<input type="checkbox"/>	STROKE	<input type="checkbox"/>	THYROID PROBLEM	<input type="checkbox"/>	RADIATION THERAPY	<input type="checkbox"/>	HIGH/LOW BLOOD PRESSURE	<input type="checkbox"/>	RESPIRATORY PROBLEMS	<input type="checkbox"/>	HEART TROUBLE	<input type="checkbox"/>	BONE DISORDER	<input type="checkbox"/>	EPILEPSY/CONVULSIONS	<input type="checkbox"/>	OSTEOPEMIA/OSTEOPOROSIS	<input type="checkbox"/>	TAKING MEDICATION:	<input type="checkbox"/>	REMOVAL OF ADENOIDS/TONSILS	<input type="checkbox"/>
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Dental History

DENTIST _____

DATE OF LAST CLEANING _____

<p>1. ARE YOU ANXIOUS OR NERVOUS ABOUT DENTAL TREATMENT? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>2. DO YOU REQUIRE PREMEDICATION FOR DENTAL TREATMENT? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>3. DO YOU FEEL PAIN TO ANY OF YOUR TEETH? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>4. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>5. HAVE YOU HAD ANY HEAD, NECK, OR JAW INJURIES? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>IF YES, PLEASE DESCRIBE:</p> <p>_____</p> <p>6. DO YOU HAVE ANY ONGOING PROBLEMS IN YOUR JAW WITH:</p> <p>A. CHRONIC CLICKING OR POPPING? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>B. PAIN? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>C. DIFFICULTY OPENING OR CLOSING? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>D. DIFFICULTY IN CHEWING? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>7. DO YOU CLENCH OR GRIND YOUR TEETH? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>8. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>9. HAVE YOU EVER HAD SPEECH THERAPY? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>IF YES, PLEASE DESCRIBE:</p> <p>_____</p>	<p>10. IS THERE ANY OUTSTANDING DENTAL TREATMENT TO BE COMPLETED? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>IF YES, PLEASE DESCRIBE:</p> <p>_____</p> <p>11. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING AND FLOSSING YOUR TEETH? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>12. DO YOU HAVE ANY OF THE FOLLOWING ORAL HABITS:</p> <p>A. NAIL BITING? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>B. THUMB SUCKING? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>C. TONGUE THRUST WHILE SWALLOWING? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>D. MOUTH BREATHING? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>13. HOW MANY TIMES A DAY DO YOU BRUSH? _____</p> <p>14. PLEASE CHECK THE BOXES BELOW WHICH DESCRIBE THE PROBLEM(S) FOR WHICH YOU ARE SEEKING TREATMENT:</p> <table border="0"> <tr> <td>CROWDING</td> <td><input type="checkbox"/></td> <td>MISSING TEETH</td> <td><input type="checkbox"/></td> </tr> <tr> <td>EXTRA SPACE</td> <td><input type="checkbox"/></td> <td>EXTRA PERMANENT TEETH</td> <td><input type="checkbox"/></td> </tr> <tr> <td>TEETH STICK OUT TOO FAR</td> <td><input type="checkbox"/></td> <td>TEETH ERUPTING IN THE WRONG POSITION</td> <td><input type="checkbox"/></td> </tr> <tr> <td>TMJ PROBLEMS</td> <td><input type="checkbox"/></td> <td>OTHER: _____</td> <td></td> </tr> <tr> <td>POOR BITE RELATIONSHIP</td> <td><input type="checkbox"/></td> <td></td> <td></td> </tr> </table> <p>15. HAVE YOU EVER HAD AN ORTHODONTIC EVALUATION OR TREATMENT BEFORE? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>IF SO, WHEN AND BY WHOM?</p> <p>_____</p>	CROWDING	<input type="checkbox"/>	MISSING TEETH	<input type="checkbox"/>	EXTRA SPACE	<input type="checkbox"/>	EXTRA PERMANENT TEETH	<input type="checkbox"/>	TEETH STICK OUT TOO FAR	<input type="checkbox"/>	TEETH ERUPTING IN THE WRONG POSITION	<input type="checkbox"/>	TMJ PROBLEMS	<input type="checkbox"/>	OTHER: _____		POOR BITE RELATIONSHIP	<input type="checkbox"/>		
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Authorization and Release

TO THE BEST OF MY KNOWLEDGE THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES TO THE PATIENT'S MEDICAL STATUS. I GIVE **CANALES** ORTHODONTICS PERMISSION TO PERFORM AN ORTHODONTIC EXAMINATION AND EVALUATION.

SIGNATURE OF PATIENT _____ DATE _____

PRINT NAME _____