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Patient No. \_\_\_\_\_

Int. App't Date \_\_\_\_\_

**Patient Information**

Patients Name \_\_\_\_\_ Nickname \_\_\_\_\_ Sex \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ E-mail Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Home Address \_\_\_\_\_  
(Street) (City/State) (Zip)

Patient resides with \_\_\_\_\_

In the event of an emergency, whom should we contact other than responsible party?

His/Her Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**Responsible Party**

Name \_\_\_\_\_  Single  Married  Divorced  Separated  Widowed  Partnered

Birthdate \_\_\_\_\_ E-mail Address \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Home Address \_\_\_\_\_  
(Street) (City/State) (Zip)

Billing Address \_\_\_\_\_  
(Street) (City/State) (Zip)

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Spouses Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Birthdate \_\_\_\_\_ E-mail Address \_\_\_\_\_

**Orthodontic Insurance Information**  YES  NO

Insured Full Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Insured Address \_\_\_\_\_  
(Street) (City/State) (Zip)

Insurance Group Number \_\_\_\_\_ Insurance ID Number \_\_\_\_\_

Employer Name \_\_\_\_\_ Insurance Company Name \_\_\_\_\_

Insurance Address \_\_\_\_\_  
(Street) (City/State) (Zip)

Is this claim the result of an accident? YES NO

Continue on back side

## Dental & Medical History

Patients Dentist \_\_\_\_\_ Last Visit \_\_\_\_\_

Did your dentist refer you?  YES  NO If no, how did you find out about us? \_\_\_\_\_

Is the patient under a physician's care?  YES  NO Physicians Name \_\_\_\_\_

If yes, for what reason? \_\_\_\_\_

Previous orthodontist consulted?  YES  NO If yes, when? \_\_\_\_\_

Other Family members treated in this office \_\_\_\_\_

What are the main concerns that you would like to address with orthodontics? \_\_\_\_\_

Please check if the patient has any allergies to the following?

Latex  Nickel/Metals  Plastic  Nuts  Other

Please list any other material or drug allergies \_\_\_\_\_

Please check any of the following condition(s) that patient has had or currently has:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Thumb/Finger Sucking            | <input type="checkbox"/> Heart Condition/Murmur | <input type="checkbox"/> Hepatitis                 |
| <input type="checkbox"/> Clinching/Grinding Teeth        | <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Epilepsy/Seizure Disorder |
| <input type="checkbox"/> TMJ                             | <input type="checkbox"/> HIV/AIDS               | <input type="checkbox"/> Prolonged Bleeding        |
| <input type="checkbox"/> Nail Biting                     | <input type="checkbox"/> Frequent Headaches     | <input type="checkbox"/> Tumor or Cancer           |
| <input type="checkbox"/> Mouth Breather                  | <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Persistent Cough          |
| <input type="checkbox"/> Tonsils and/or Adenoids Removed | <input type="checkbox"/> Abnormal Bleeding      | <input type="checkbox"/> Tuberculosis              |
| <input type="checkbox"/> Canker/Cold Sores               | <input type="checkbox"/> Emotional Disturbance  | <input type="checkbox"/> Fainting Spells           |
| <input type="checkbox"/> Dental/Tooth Injuries           | <input type="checkbox"/> ADD                    | <input type="checkbox"/> Rheumatic Fever           |
| <input type="checkbox"/> Facial/Jaw Injury               | <input type="checkbox"/> Mental Disorders       |  |
| <input type="checkbox"/> Speech Problems                 | <input type="checkbox"/> Arthritis              |  |

Other \_\_\_\_\_

Please list any medications the patient is currently taking \_\_\_\_\_

The information given is correct to the best of my knowledge. It is my responsibility to inform this office of any changes.

I authorize release of any information relating to orthodontic insurance claims

Signature (required)

Relationship to patient

Date

Drs. Notes: