



VLACHOS ORTHODONTICS

3045 Independence Dr., Homewood, AL 35209
www.vlachosorthodontics.com • 205-871-5557

PATIENT INFORMATION

Patient Name _____ Male Female
Social Security # _____ Birth Date _____ Driver License # _____
Home Address _____
City _____ State _____ Zip _____
Primary Phone # _____ home cell Ok to leave Message? Y N
Secondary Phone # _____ home cell other Ok to leave Message? Y N
Email _____
Employer's Name _____ Occupation _____

SPOUSE / EMERGENCY CONTACT INFORMATION

Marital Status Single Married Divorced Widowed Significant Other

Spouse / Partner's Name _____
Emergency Contact Name _____
Phone # _____ Relation to you _____
Address _____
City _____ State _____ Zip _____

Person(s) OK to release appointment or medically related information to concerning you.

_____ Relation(s) _____

INSURANCE INFORMATION

Primary Insurance Company _____ Phone Number _____
Group # _____ Policy # _____ Member ID # _____
Policy Holder's Name _____ Relation _____
Policy Holder's Social Security # _____ Policy Holder's Birth Date _____
Employer _____ Work Phone # _____
Co-pay (if known) _____ Deductible (if known) _____

Secondary Insurance Company _____ Phone Number _____
Group # _____ Policy # _____ Member ID # _____
Policy Holder's Name _____ Relation _____
Policy Holder's Social Security # _____ Policy Holder's Birth Date _____
Employer _____ Work Phone # _____
Co-pay (if known) _____ Deductible (if known) _____

DENTAL HISTORY

General Dentist _____ Last Visit _____

How did you hear about our Practice?

Ad Internet Family or Friend Physician Other

Name of person referring (if applicable) _____

What are the main concerns you would like orthodontics to accomplish?

Have you visited an orthodontist before? Y N

When? _____ Reason? _____

Have your tonsils or adenoids been removed? Y N

Have you ever experienced jaw joint pain/discomfort (TMJ/TMD) ? Y N

Do you have any missing or extra permanent teeth? Y N

Have you ever had an injury to (*select all that apply*): Teeth Mouth Chin

Do you have speech problems? Y N If so, explain _____

Do your gums bleed? Y N Do you smoke? Y N

Do you like your smile? Y N

Do you currently or have you ever had any of the following habits

(*check all that apply*)

Clenching/Grinding Teeth

Mouth Breathing

Thumb / Finger Sucking

Lip Sucking/Biting

Nail biting

Chewing / Eating Problem

MEDICAL HISTORY

Are you currently being treated by a physician? Y N Reason _____

Physician _____ Last Visit _____ Phone _____

Do you have any allergies/sensitivities to medications or latex? Y N

If yes, please list allergies.

Are you currently taking any prescription or over-the-counter medications? Y N

Please list, with dosage. _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Apidex, Fastin (brand names of Phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine)? Y N

Have you had any serious illnesses or operations? If yes, describe:

Have you ever had a blood transfusion? Y N

If yes, give approximate dates: _____

(Women)

Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Check if you have or have ever had any of the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |

AUTHORIZATION

- ❖ I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my medical status.
- ❖ I hereby authorize the release of any information pertaining to my medical treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payment of any benefits to the office. I understand that I am responsible for any amount not covered by insurance.
- ❖ I understand that where appropriate, credit bureau reports may be obtained.

Patient Signature and/or Responsible Party

Date