THE BRACE PLACE

JAMES M. CROUSE DDS–PA

Specialist in Orthodontics

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 lonimin, 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:

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