Dr. Darrin Storms

Welcome!

Date: ______ / ______ / ______

TELL US ABOUT YOURSELF

Your Name: ____________________ ☐ Male ☐ Female

Nickname: ____________ Date of Birth: ____________ Age: ________

Your Home Address: ____________________ Home Phone: ____________

____________________ Cell Phone: ____________

Hobbies / Sports:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Spouse's Name: ____________

List children: ____________________ Age ________

____________________ Age ________

____________________ Age ________

PATIENT / RESPONSIBLE PARTY INFORMATION

PATIENT INFORMATION:

Are you to be listed as the primary or secondary financially responsible party? ☐ Primary ☐ Secondary

Name: ____________________ Date of Birth: ____________

Mailing Address: ____________________ Home Phone: ____________

____________________ Cell Phone: ____________

Home E-Mail: ____________________

Employer: ____________________ Work Phone: ____________

Job Title: ____________________ # yrs employed: ____________

Work E-Mail: ____________________

Social Security No: ________ - ________ - ________ (required for insurance purposes)

SPOUSE'S INFORMATION:

Is your spouse to be listed as the primary or secondary financially responsible party? ☐ Primary ☐ Secondary

Name: ____________________ Date of Birth: ____________

Mailing Address: ____________________ Home Phone: ____________

____________________ Cell Phone: ____________

Home E-Mail: ____________________

Employer: ____________________ Work Phone: ____________

Job Title: ____________________ # yrs employed: ____________

Work E-Mail: ____________________

Social Security No: ________ - ________ - ________ (required for insurance purposes)

Your Dentist: ______________________ Date of last dental cleaning: ______________

What is your primary concem about your smile? ______________________

Whom may we thank for referring you? ☐ Dentist ☐ Physician ☐ Friend ☐ Staff Member ☐ Other

Name: ______________________

Are you experiencing any dental pain? ☐ Yes ☐ No Describe: ______________________

Have you had any pain or tenderness in your jaw joints? ☐ Yes ☐ No Due to an accident? ☐ Yes ☐ No

Do you have any clicking, popping, grinding or locking in your jaw joints? ☐ Yes ☐ No If so, where? ______________

Description of event, trauma or accident: ______________________

Any body piercings / jewelry on lips, cheeks, nose or tongue? ☐ Yes ☐ No If so, where? ______________

Are you currently taking any prescription medications? ☐ Yes ☐ No If so, what? ______________

Are you taking Fosamax for bone strengthening? ☐ Yes ☐ No

Regarding females of child bearing age: Pregnant? ☐ Yes ☐ No Number of months pregnant: __________months

Birth Control Pills? ☐ Yes ☐ No

MEDICAL and DENTAL HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS? ***Conditions listed in RED may require antibiotics prior to treatment***

Heart Attack	☐	Stroke	☐	Epilepsy	☐
Heart Murmur	☐	Hepatitis	☐	Abnormal Bleeding	☐
Congenital Heart Defect	☐	Diabetes	☐	Frequent Fever Blisters	☐
Mitral Value Prolapse	☐	Ulcers / Colitis	☐	Shingles	☐
Artificial Valves	☐	Asthma	☐	Kidney / Liver Problems	☐
Pacemaker	☐	Emphysema	☐	Frequent Headaches	☐
Rheumatic Fever	☐	Sinus Problems	☐	Psychiatric Therapy	☐
High Blood Pressure	☐	Scarlet Fever	☐	Drug / Alcohol Abuse	☐
Cancer	☐	Tuberculosis	☐	HIV+ / AIDS	☐

Other medical conditions not listed: ______________________

ALLERGIES

Penicillin	☐	Aspirin	☐	Local Anesthetics	☐
Amoxicillin	☐	Tylenol	☐	Codeine	☐
Tetracycline	☐	Ibuprofen	☐	Latex Sensitivity	☐

Other medication allergies not listed: ______________________

DENTAL HISTORY

Previous Orthodontic Treatment	☐	Gag Easily	☐	Tooth Sensitivity	☐
(When: ____________)		Tongue Thrusting Habit	☐	Bad Breath	☐
Gum Disease	☐	Thumb Sucking Habit	☐	How often do you brush per day? ________	
Bleeding Gums	☐	Oral Surgery	☐	How often do you floss per day? ________	

Other dental conditions not listed: ______________________

IN CASE OF EMERGENCY

Name of local friend or relative (not living at the same address): ______________________

Relationship to patient: ____________ Home Phone: ______________ Cell Phone: ______________

REGARDING YOUR ORTHODONTIC INSURANCE *(Please complete an Orthodontic Insurance Information form)*

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes **Dr. Storms** to submit claims without obtaining my signature on each and every claim to be submitted.

NOTICE OF PRIVACY PRACTICES

We are dedicated to protecting your personal medical and dental information and following all provisions required by law. You are entitled to review our complete Privacy Notice which describes how we may use and disclose your medical and dental records while you are receiving care at **Storms Orthodontics**.

I understand the information that I have given is correct to the best of my knowledge and it my responsibility to inform this office of any changes in my address, employment or medical status. I also grant permission to discuss treatment recommendations with my dentist and discuss both medical and dental information including initial reports, progress reports and final reports regarding oral hygiene and/or treatment.

______________________ ______________

Signature of Patient Date

______________________ ______________

Doctor's Signature Date