SMILE DESIGN ORTHODONTICS
(281) 481-9575 | SDOHOUSTON.COM
13310 Beamer Road, Suite F | Houston, TX | 77089

Patient Information

NAME _____ PREFERRED NAME _____ M F

SSN _____ DOB _____ GRADE _____ SCHOOL ATTENDS _____

HOME PHONE _____ CELL PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PATIENT LIVES WITH WHOM/RELATIONSHIP _____

NAME OF SIBLINGS & AGES _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

Responsible Party (select only one)

☐ SELF ☐ MOTHER ☐ FATHER ☐ STEP-PARENT ☐ GUARDIAN

RESPONSIBLE PARTY FULL NAME _____

DATE OF BIRTH _____ SSN _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CELL PHONE _____

WORK PHONE _____

EMPLOYER _____

OCCUPATION _____

EMAIL _____

Primary Dental Insurance

☐ CHECK HERE IF NO ORTHODONTIC COVERAGE WILL BE APPLIED

INSURANCE COMPANY _____ INSURANCE PHONE NUMBER _____

EMPLOYER/GROUP NAME _____ GROUP NUMBER _____

SUBSCRIBER NAME _____ SUBSCRIBER ID _____

DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

Secondary Dental Insurance

☐ CHECK HERE IF NO SECONDARY INSURANCE

INSURANCE COMPANY _____ INSURANCE PHONE NUMBER _____

EMPLOYER/GROUP NAME _____ GROUP NUMBER _____

SUBSCRIBER NAME _____ SUBSCRIBER ID _____

DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

Emergency Contact Information (OTHER THAN RESPONSIBLE PARTY)

NAME _____ RELATIONSHIP TO PATIENT _____

BEST PHONE _____

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

Please check Yes or No to the following questions:

HAVE YOU SEEN A DENTIST IN THE PAST 6 MONTHS? Y ☐ N ☐

Dentist or Practice Name: _____

DO YOU HAVE CAVITIES OR GUM PROBLEMS THAT NEED TREATMENT OR HAVE BEEN TREATED? Y ☐ N ☐

If yes, please explain: _____

HAVE YOU HAD ANY INJURIES TO THE TEETH, JAWS, OR HEAD? Y ☐ N ☐

If yes, please explain: _____

DO YOU REGULARLY SEE A PHYSICIAN OR FAMILY DOCTOR? Y ☐ N ☐

Doctor or Practice Name: _____

DO YOU HAVE A MEDICAL, PSYCHIATRIC, PHYSICAL OR OTHER HEALTH CONDITION THAT REQUIRED PAST OR ONGOING MEDICAL DOCTOR VISITS AND/OR TREATMENT? Y ☐ N ☐

If yes, please explain: _____

DO YOU HAVE ANY HISTORY OF BLEEDING PROBLEMS? Y ☐ N ☐

If yes, please explain: _____

DO YOU TAKE ANY PRESCRIPTION OR OVER-THE-COUNTER MEDICATIONS? Y ☐ N ☐

If yes, please explain: _____

DO YOU HAVE ANY ALLERGIES TO MEDICATION, FOOD, OR ENVIRONMENTAL SUBSTANCES? Y ☐ N ☐

If yes, please explain: _____

HAVE YOU HAD AN ORTHODONTIC EVALUATION OR ORTHODONTIC TREATMENT BEFORE? Y ☐ N ☐

If yes, please explain: _____

ARE YOU PREGNANT OR IS THERE A CHANCE YOU ARE PREGNANT? Y ☐ N ☐

IF POSSIBLE, WOULD YOU LIKE TO GET BRACES TODAY? Y ☐ N ☐

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 AND DENTAL STATUS. I GIVE SMILE DESIGN ORTHODONTICS PERMISSION TO PERFORM THE NECESSARY DENTAL SERVICES THAT THE PATIENT MAY NEED.

SIGNATURE OF PATIENT (OR PARENT IF MINOR) _____ DATE _____

PRINT NAME _____ RELATIONSHIP TO PATIENT _____