www.myersorthodontics.com

Patient Name ______________________________Address __________________________
City ___________________St____Zip________Phone(home)____________Cell___________
D.O.B. ___________ Sex _____Social Security # ___________ E-Mail______________
Brothers/Sisters (age) 1 ______________ 2) ______________3) _____________
Family members treated ____

Primary Responsible Party

(Adult present with Patient)

Name ______________relation_________
Address (if different from above) ____________
City ____________State___Zip________
Home Phone_________Cell____________
Birthday __________ Sex_____________
Child lives with _____________________

Secondary Responsible Party

Name _______________relation________
Address(if different from above) ____________
City ____________State___Zip________
Home Phone________ Cell ___________
Birthday___________ Sex ____________
Child lives with _____________________

Employer Information

Company's Name ____________________
Occupation__________________________
Address_____________________________
City ______________State___Zip______
Phone _____________EXT ____________

Employer Information

Company's Name ____________________
Occupation__________________________
Address_____________________________
City ______________State___Zip______
Phone _____________EXT ____________

Primary Dental Insurance Information

Insured's Name _____________________
Social Security # ___________________
Date of Birth of Policy Holder__________
Insurance Company __________________
Address_____________________________
City ______________State___Zip______
Insurance Phone_____________Ext#____
Group# ____________________________

Secondary Dental Insurance Information

Insured's Name _____________________
Social Security # ___________________
Date of Birth of Policy Holder__________
Insurance Company __________________
Address_____________________________
City ______________State___Zip______
Insurance Phone_____________Ext#____
Group# ____________________________

Myers Orthodontics
SPECIALIST IN ORTHODONTICS FOR ADULTS & CHILDREN

Medical Information

A. Is the patient:

	Yes	No
Under medical care?	☐	☐
Taking any medications?	☐	☐
Allergic to anything?	☐	☐

If yes What? ____

If yes What ? ____

If yes, what? ____

Who can we thank for referring you? ________________________________

X__________________ Sign here X__________ X__________________ Sign here

Patient Signature **Date** **Parent/Legal Guardian Signature**

Dental History

Date of Last Cleaning:____/___/______

A. General

	Yes	No
Has the patient seen a general dentist in the last year?	☐	☐
Any pain, clicking, or discomfort in or near the ears?	☐	☐
Has the mouth, face, or teeth been injured by a fall or accident?	☐	☐
Have you been informed of missing or extra permanent teeth?	☐	☐
Are you aware of any "gum" problems?	☐	☐
Have the patient's tonsils or adenoids been removed?	☐	☐
Has the patient been examined by an orthodontist before?	☐	☐

B. Does the patient have or has the patient ever had any of the following habits?

	Yes	No		Yes	No
Cheek, tongue or lip chewing?	☐	☐	Grinds teeth?	☐	☐
Sucks thumb/fingers?	☐	☐	Tongue thrusting?	☐	☐
Mouth breathing?	☐	☐	Speech problems?	☐	☐
Clenches teeth?	☐	☐			

If yes when? ____

Reason for your orthodontic exam: ____

Other Information

Dentist Name: ______________________________

Physician Name:______________________________

School Name:______________________________

Sports or Hobbies or Musical Instuments?______________________________

2 Emergency contacts: nearest relative

Name:____________________relation______________

Address:____________________Phone:__________

Name: ____________________relation______________

Address: ____________________Phone:__________

Request of Release of Records

I, ____________________, hereby request and give my permission to Beau R. Myers, D.D.S., to provide Dentists, Medical Doctors an/or insurance with any and all information he/she may request with respect to the orthodontic care of _______________. Such records may include medical care and treatment, illness or injury, dental history, medical history, consultation, prescriptions, X-rays, models and copies of all dental records and medical records.

Signed: ________________________________ Date:________________
(Patient)

Signed:________________________________ Date:________________
(Parent, Legal Guardian or Custodian of the Patient if patient is a Minor)

HIPPAA Privacy Rule gives you the patient the right to request restrictions on uses and disclosures of your Protected Health Information (PHI). You also have the right to request confidential communications or that communications of PHI be made by alternative means, such as sending correspondence to an alternate address or call a different phone number than what is listed.