SOUTH LYON
ORTHODONTICS
Where Beautiful Smiles Begin

RENÉE E. GERAN, DDS, MS

The benefits of a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset.

Please fill out this form completely. The better we communicate, the better we can care for you.

1 ABOUT YOU

Today's Date _____

Name: _____
LAST FIRST MI

E-mail Address: _____

I prefer to be called _____

Birthdate: ___/___/___ Age: _____ ❑ Male ❑ Female

Home Address: _____
APT. / CONDO #

_____
CITY STATE ZIP

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Hm.#: _____ Pager/Other# _____

Wk.#: _____ Ext: _____

Employer: _____

Employer's Address: _____

How long there: _____ Occupation: _____

When & where are the best times to reach you? _____

_____

Whom may we thank for referring you? _____

Other family members seen by us: _____

General Dentist: _____

Last Visit Date: _____

2 SPOUSE INFORMATION

His/Her Name: _____

Employer: _____

Wk #: ( ) _____ Ext: _____

SS#: _____

Birthdate: ___/___/___

Person Responsible for Account: _____

Wk #: ( ) _____ Ext: _____

Billing Address: _____

Relation: _____ SS#: _____

Employer _____

3 ORTHODONTIC INSURANCE

Primary

Orthodontic Coverage? ❑ Yes ❑ No

Dental Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan Local or Policy #) _____

Insured's Name: _____ Relation _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Secondary

Orthodontic Coverage? ❑ Yes ❑ No

Dental Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan Local or Policy #) _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____

Subscriber ID #: _____

Insured's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: _____ Relation: _____

Wk#: _____

Hm #: _____

4 MEDICAL HISTORY

Primary

Do you have a physician? ❑ Yes ❑ No

Physician's Name: _____

Phone #: _____ Date last visit: _____

(Continued On Back)

4 MEDICAL HISTORY *Continued*

Your current physical health is: ❑ **Good** ❑ **Fair** ❑ **Poor**

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: _____

Are you taking any prescription / over- the-counter drugs? ❑ Yes ❑ No

Please list each one: _____

For Women: Are you using a prescribed method of birth control? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Week #: _____

Are you nursing? ❑ Yes ❑ No

Have you ever had any of the following diseases or medical prblems?

Y	N	Abnormal Bleeding	Y	N	Hemophilia
Y	N	Anemia	Y	N	Hepatitis
Y	N	Artificial Bones /Joints / Valves	Y	N	High/Low Blood Pressure
Y	N	Asthma / Arthritis	Y	N	HIV+ / AIDS
Y	N	Blood Transfusion	Y	N	Hospitalized for Any Reason
Y	N	Cancer / Chemotherapy	Y	N	Kidney Problems
Y	N	Congenital Heart Defect	Y	N	Mitral Valve Prolapse
Y	N	Diabetes	Y	N	Psychiatric Problems
Y	N	Difficulty Breathing	Y	N	Radiation Treatment
Y	N	Drug / Alcohol Abuse	Y	N	Rheumatic / Scarlet Fever
Y	N	Emphysema	Y	N	Severe/Frequent Headaches
Y	N	Epilepsy/Seizures/Fainting	Y	N	Shingles
Y	N	Fever Blisters / Herpes	Y	N	Sickle Cell Disease / Traits
Y	N	Glaucoma	Y	N	Sinus Problems
Y	N	Heart Attack / Stroke	Y	N	Tuberculosis (TB)
Y	N	Heart Murmur	Y	N	Ulcers / Colitis
Y	N	Heart Surgery/Pacemaker	Y	N	Venereal Disease

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Latex
Y	N	Any Metals/Plastics	Y	N	Penicillin
Y	N	Codeine	Y	N	Tetracycline
Y	N	Dental Anesthetics	Y	N	Other
Y	N	Erythromycin			

Please list other drugs/materials that you are allergic to: _____

_____

_____

5

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

_____

Have you ever been evaluated or had orthodontic treatment ❑ Yes ❑ No

Have you ever had a serious / difficult problem associated with previous dental work? ❑ Yes ❑ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ❑ **Yes** ❑ **No**

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Do you like your smile? ❑ Yes ❑ No Gums ever bleed? ❑ Yes ❑ No

Have you ever had an injury to your: Teeth Chin (Please Circle)

Do you have any speech problems? _____

Do you generally breathe through your mouth? ❑ Yes ❑ No

If yes, please circle: While Awake? While Asleep?

Do you have any missing or extra permanent teeth? ❑ Yes ❑ No

Have you ever taken Fosamax, or any other bisphosphonate? ❑ Yes ❑ No

Have you ever taken Phen-Fen? ❑ Yes ❑ No

Do you smoke or use tobacco in any form? ❑ Yes ❑ No

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 confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental office to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature Date

6 Thank you for filling out this form completely.

This office reserves the right to verify the credit status of potential patients and / or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

_____

Signature Date

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office.

_____

Signature Date

Our Office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein.

Doctor's Comments: Initials: _____ Date: _____

_____

_____

_____

_____

_____