Date:___/____/_____

NEW PATIENT INFORMATION- ADULT

(Please Print)

PATIENT INFORMATION

Patient's last name: Middle: First:			Preferred name: SSN:		
Preferred office location ❑ Edmond ❑ Stillwater	Cell phone:	Home phone:	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:		City:	State:	ZIP Code:	
Occupation:	Employer:		Employer phone no.: ( )		
Current Dentist:	Patient Email:				

How did you hear about Kierl Orthodontics? Please list names so we can thank them:

❑ Dentist referral_____
❑ Internet search
❑ Website
❑ School Sponsorships
❑ Friend _____
❑ Family_____
❑ Drove by/sign
❑ Other_____

Other family members seen here:

ORTHODONTIC INSURANCE INFORMATION

Insured's name:		Relationship to patient: ❑ Mother ❑Father ❑Self ❑ Spouse ❑ Other:_____	
Birth date: / /	Address (if different):		**Phone** Home:
Occupation:	Employer:	Employer address:	Cell: Work:
Is this patient covered by insurance? ❑ Yes ❑ No			
Primary Insurance company:		Ins company phone #:	
Insured's SSN:		Group no.:	ID number:
Name of secondary insurance if applicable:		Secondary insurance Phone #:	
Insured's name:	Insured's SSN:	Group no.:	ID number:

Date:___/____/_____

MEDICAL HISTORY

Current Primary Care Physician:_____ **Approximate date of last visit:**_____

Are you taking any medication? Yes: ___ No: ___
Please list: _____
_____

Are you allergic to any medication? Yes: ___ No: ____
Please list: _____

Have you ever been involved in a serious accident? Yes ___ No ___

Please check any conditions below that you have had or currently have:

Yes	**No**	**ADD**	**Yes**	**No**	**Heart Murmur**
Yes	**No**	**ADHD**	**Yes**	**No**	**Hepatitis**
Yes	**No**	**Allergy to Nickle**	**Yes**	**No**	**HIV/Aids**
Yes	**No**	**Anemia**	**Yes**	**No**	**Latex Allergy**
Yes	**No**	**Asthma**	**Yes**	**No**	**Multiple Sclerosis**
Yes	**No**	**Asperger Syndrome**	**Yes**	**No**	**Prolonged Bleeding**
Yes	**No**	**Autism**	**Yes**	**No**	**Radiation/Chemotherapy**
Yes	**No**	**Diabetes**	**Yes**	**No**	**Rheumatic Fever**
Yes	**No**	**Epilepsy**	**Yes**	**No**	**Tumor/Cancer**

Other:
_____
_____

DENTAL HISTORY

What concerns you most about your teeth or your smile?

Patient concerns:_____

Dentist concerns:_____

Other concerns regarding treatment: _____

Yes	**No**	**Have you seen an orthodontist? If yes, who:**
Yes	**No**	**Has anyone in your family received orthodontic treatment?**
		How did they feel about the result?_____
Yes	**No**	**Are you presently in dental pain?**
Yes	**No**	**Have you ever had a negative reaction to a dental procedure?**
Yes	**No**	**Have you ever lost or chipped any teeth or had major injuries to the face or mouth?**
Yes	**No**	**Do you have a history of periodontal disease?**
Yes	**No**	**Do your gums bleed when you brush?**
Yes	**No**	**Is any part of your mouth sensitive to temperature or pressure?**
Yes	**No**	**Are you a mouth breather?**
Yes	**No**	**Do you have any type of thumb, finger, or tongue habit?**
Yes	**No**	**Are your teeth or jaws sore or uncomfortable when you wake up in the morning?**
Yes	**No**	**Are you aware of your jaws popping or clicking?**
Yes	**No**	**Do you clinch your teeth during the day?**
Yes	**No**	**Have you ever been told that you grind your teeth?**
Yes	**No**	**Do you experience tension headaches or ringing in the ears?**
Yes	**No**	**Are you pregnant?**
Yes	**No**	**Has menstruation started? (Used to predict patients growth spurt)**

If patient is under the age of 16, height of parents? Mother:_____ **Father:**_____

Date:___/____/_____

RELEASE AND WAIVER

I authorize the release of any information necessary to process insurance claims.
I authorize payment directly to Kierl Orthodontics of Insurance benefits otherwise payable to me.

Signature:_____ **Date:**_____

Benefits of Treatment

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides and improvement in the appearance of the teeth, the general function of the teeth, and in general dental health. Teeth, gums, and jaws are intricate parts of the body and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be movement of teeth after treatment. This is why retention is a vital part of treatment. I have read and understand this paragraph and acknowledge that I have read a copy of the **Orthodontic Treatment Information**. I have truthfully answered all of the above questions and agree to inform the office of any changes in my medical or dental history. In addition I authorize Dr. Kierl to perform a complete orthodontic evaluation.

Signature:_____ **Date:**_____

Photo Waiver

From time to time Dr. Kierl makes use of patient materials like photographs and x-rays in teaching and public presentations. Please initial below to signify permission to use yours.

Intials: _____