Image Orthodontics
DR. RYAN HELMS | DDS MSD

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Confidential Patient Information			
Date:		Whom may we thank for referring you to our practice?	
First Name:	Middle Initial:	Last Name:	
Sex:	Age:	Birthdate:	
Prefers to be called:	Phone #:	Cell #:	Email:
Address:	City:	State:	Zip:

Financial Party Information			
Employed By:	Occupation:	Work Phone:	Marital Status:
Spouse's Name:	Occupation:	Work Phone:	Employed:
If you have children, please list below.			
Child Name:		Birthdate:	
Child Name:		Birthdate:	
Person Responsible for Account:	Social Security #:	Main Phone:	
Address:	City:	State:	Zip:
Business Phone:		Cell Phone:	
Contact in Case of an Emergency			
Name:	Phone #:	Cell #:	

Dental Insurance		
Primary Insurance Co:	Group Number:	Phone Number:
Ortho Coverage?		
Insured's Name:	SSN:	Birthdate:
Secondary Insurance Co:	Group Number:	Phone Number:

Ortho Coverage:		
Insured's Name:	SSN:	Birthdate:
Other Insurance Information:		

Dental History	
Patient Dentist Name:	Date of last dental visit?
Please write 'Yes' if the patient has had any of the conditions listed below either now or in the past. Cannot be blank.	
Have there been any injuries to the face, mouth, or teeth?	
Have you had or do you presently have any of the following habits? Thumb or finger sucking? Lip biting? Snoring? Grinding of teeth? Mouth breathing?	
Have you been informed of any missing or extra permanent teeth?	
Are you aware of any sores, lumps or irritated areas in the mouth?	
Has an orthodontist been consulted previously? If so, who? When?	
Have you ever been treated for: Bad bite: TMJ: Periodontal disease: If so, by whom:	
Do you have any speech problems?	
Are you concerned or anxious about orthodontic treatment?	
Are you concerned about the appearance of your teeth?	
Is there anything you would like to change about your smile? If so, what?	
What aspect of dental treatment are you most concerned with? Quality Cost Most concerned with discomfort Most concerned with time	
Reason for consultation (chief concern):	
Has there ever been any orthodontic treatment for any other member of your family?	
Were they satisfied with the results?	

Dr. who treated children:	Dr. who treated Spouse?	Dr. who treated other family:

Medical History
Is your general health good at this time?
Is the patient now under the care of a physician at this time? If so, please explain:
Are you taking any medication? If so, what?
Are you allergic to any medication? (Penicillin, Sulfa, etc.)
Have you ever had a serious illness or hospitalization? If so, what for?
Have you had your tonsils or adenoids removed? If so, at what age?
Have you ever been advised by your physician to take an antibiotic prior to any dental treatment? If yes, antibiotic name and method:
Pharmacy:
Do you use tobacco (smoking or chewing)?

Your approximate height?	Your approximate weight?

WOMEN

Are you pregnant or considering pregnancy during the next two years?

Are you nursing?

Are you currently taking medication for birth control?

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?

Tuberculosis	Diabetes	ADD
Endocarditis	Respiratory lung disease	Kidney trouble
Heart condition	High blood pressure	Liver disease
Pacemaker	Low blood pressure	Liver disease
Heart angina	Hepatitis, Type	Drug addiction
Heart attack	Venereal disease	Headaches
Mitral valve prolapse	Herpes (oral cold sore)	Earaches
Congenital heart disease	Blood disorders bleeding problems	Jaw clicking
Artificial heart valve	Inflammatory rheumatism	Allergies
Heart surgery, Date	Ulcers	Allergy to metal
Heart murmur	Stroke	Allergy to latex

Rheumatic fever	Anemia	Arteriosclerosis
Jaw pain	Arthritis/Osteoporosis/Bisphosphonates	
Asthma	Tonsillitis	Prosthetic (artificial) joints
Epilepsy	Emotional problems	X-ray/Radiation (cancer) therapy
Glaucoma	AIDS/HIV+	Fainting spells

I, the undersigned, have completed the health questionnaire and certify that the preceding information is true and correct. THIS OFFICE WILL NOT BE HELD RESPONSIBLE FOR ANY PROBLEMS ARISING OUT OF INADEQUATE INFORMATION. I grant authority to the Doctor and Staff to perform all procedures and treatments in my best interest. I authorize the Orthodontist to share treatment information with collaborating dentists and surgeons when appropriate. I authorize the Orthodontist to submit treatment information pertinent to this patient to the Insurance Company for billing purposes only. I understand that, when appropriate, Credit Bureau reports may be obtained.