Dr. SeaMount
Orthodontist

Thank you for selecting our office for your comprehensive orthodontic needs! It is our goal to provide you with the best possible care. To help us meet all of your needs, please fill out this form completely. Thank you!

Patient Information

Name _____Birthdate _____ Home Phone _____
Address _____ City _____ State _____ Zip _____
If student, Name of school _____
Spouse or Parents' Names _____
Whom may we thank for referring you? _____
Have we treated any of your family members? _____
Family e-mail address _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Social Security # _____Home Phone_____Cell Phone_____E-mail _____
Name of Person Responsible for this Account _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Social Security # _____Home Phone_____Cell Phone_____E-mail _____

Dental Insurance Information

Name of Card Holder _____ Relationship _____
Birthdate _____ Social Security # _____ Ins Effective Date _____
Name of Employer _____ Union or Local #_____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Policy/ID# _____
Ins Co Address _____ City _____ State _____ Zip _____
Ins Co Phone _____ Lifetime Maximum _____ Percent _____

If you have additional dental insurance, please complete the following:

Name of Card Holder _____ Relationship _____
Birthdate _____ Social Security # _____ Ins Effective Date _____
Name of Employer _____ Union or Local #_____ Work Phone_____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Policy/ID# _____
Ins Co Address _____ City _____ State _____ Zip _____
Ins Co Phone _____ Lifetime Maximum _____ Percent _____

Patient Medical History

Physician _____ Office Phone _____

	Yes	No
1. Are you under any medical treatment now?	◯	◯
2. Have you ever been hospitalized for any surgical operation or serious illness within the past 5 years? If yes, please explain _____ _____	◯	◯
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking?_____	◯	◯
4. Have you ever taken Phen-Fen/Redux?	◯	◯
5. Do you use tobacco?	◯	◯
6. Do you use controlled substances?	◯	◯
7. Are you wearing contact lenses?	◯	◯

	Yes	No
8. Are you allergic to or have any reactions to the following?		
Local Anesthetics (ex. Novacaine)	◯	◯
Penicillin	◯	◯
Other Antibiotics Sulfa Drugs	◯	◯
Barbiturates	◯	◯
Sedatives	◯	◯
Iodine	◯	◯
Aspirin	◯	◯
Any metals (ex. nickel, mercury, etc.)	◯	◯
Latex Rubber	◯	◯
Other (please list) _____		
9. Women Only		
a) Are you pregnant or think you may be pregnant?	◯	◯
b) Are you nursing?	◯	◯
c) Are you taking oral contraceptives?	◯	◯

Do you have or have you had any of the following?	Yes	No		Yes	No		Yes	No
High Blood Pressure	◯	◯	Heart Disease	◯	◯	Stomach Troubles/Ulcers	◯	◯
Heart Attack	◯	◯	Cardiac Pacemaker Heart	◯	◯	Chest Pains	◯	◯
Rheumatic Fever	◯	◯	Murmur	◯	◯	Easily Winded Stroke	◯	◯
Swollen Ankles	◯	◯	Angina	◯	◯	Hay Fever/Allergies	◯	◯
Fainting/Seizures	◯	◯	Frequently Tired	◯	◯	Tuberculosis	◯	◯
Asthma	◯	◯	Anemia	◯	◯	Radiation Therapy	◯	◯
Low Blood Pressure	◯	◯	Emphysema	◯	◯	Glaucoma	◯	◯
Epilepsy/Convulsions	◯	◯	Cancer	◯	◯	Recent Weight Loss	◯	◯
Leukemia	◯	◯	Arthritis	◯	◯	Liver Disease	◯	◯
Diabetes	◯	◯	Joint Replacement	◯	◯	Heart Trouble	◯	◯
Kidney Disease	◯	◯	Hepatitis/Jaundice	◯	◯	Respiratory Problems	◯	◯
AIDS or HIV Infection	◯	◯	Sexually Trans. Disease	◯	◯	Mitral Valve Prolapse	◯	◯
Thyroid Problem	◯	◯				Other _____	◯	◯

Please list the names of any brothers or sisters (or children)

Name _____ Age _____ Name _____ Age _____
Name _____ Age _____ Name _____ Age _____

Patient Dental History

Dentist Name _____ Address _____ Phone _____
How long has it been since your last visit to the dentist? _____

	Yes	No
Do you make regular dental visits?	◯	◯
Do you clench or grind your teeth?	◯	◯
Does your Jaw click or pop?	◯	◯
Have you experienced any pain or soreness in the muscles of your face or around your ears?	◯	◯
If yes, please explain _____		
Are any of your teeth loose?	◯	◯
Have you ever had any periodontal (gum) treatment or surgery?	◯	◯
If yes, please explain _____		
Have you ever had any permanent or "extra" (supernumerary)	◯	◯
teeth removed?	◯	◯
Are any of your teeth sensitive to hot or cold?	◯	◯
Do you have a mouth breathing habit, snoring or difficulty breathing?	◯	◯

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.
I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. If there are any changes later to this history record or medical/dental status I will so inform the practice.
I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services.
I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____
Signature of patient or responsible party date

_____ _____
Signature of dental staff member date

Relationship to Individual: _____
Patient Name: _____
Address: _____Phone: _____

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