DEMKO ORTHODONTICS
Orthodontics & Dentofacial Orthopedics Adults & Adolescents

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PATIENT INFORMATION

Date _____

www.DemkoSmiles.com

Patient's Full Name _____ Prefers to be Called _____
First, Middle, Last

Patient's Address _____ Home Phone ( ) _____
Street City State Zip

Patient's Birthday ____/____/____ Age _____ ❑ Male ❑ Female Cell Phone ( ) _____
Month Day Year

Patient's Dentist _____
Name, City, State, Phone No.

Whom may we thank for referring you? _____ Other family members seen by us _____

Children and ages of siblings _____ E-mail _____

RESPONSIBLE PARTY INFORMATION

Name _____ ❑ Married ❑ Single ❑ Divorced Home Phone ( ) _____
First, Middle, Last

Home Address _____ No. of Years at Address _____
Street City State Zip

Your Relationship to Patient _____ Your Birthday ____/____/____ Email _____
Month Day Year

Your Employer _____ Social Security No. ____/____/____

Your Occupation _____ Work Phone ( ) _____ Cell Phone ( ) _____ No. of Years Employed ____

Spouse's Name _____ Spouse's Birthday ____/____/____ Email _____
First, Middle, Last *Month Day Year*

Spouse's Employer _____ Work Phone ( ) _____ Cell Phone ( ) _____

Spouse's Occupation _____ Social Security No. ____/____/____ No. of Years Employed ____

INSURANCE INFORMATION

Primary Orthodontic Insurance

Subscriber's Name _____

Social Security No. ____/____/____

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone No. _____

Group No. (Plan, Local, or Policy No.) _____

Relationship to Patient _____

Subscriber's Birthday ____/____/____
Month Day Year

Subscriber's Employer _____

I have been informed of the treatment plan. I authorize release of any information related to this claim.

_____
Signed (Patient, or Parent if Minor) *Date*

I hereby authorize payment directly to the below named dentist of the group insurance benefits otherwise payable to me.

_____
Signed (Insured Person) *Date*

Secondary Orthodontic Insurance

Subscriber's Name _____

Social Security No. ____/____/____

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone No. _____

Group No. (Plan, Local, or Policy No.) _____

Relationship to Patient _____

Subscriber's Birthday ____/____/____
Month Day Year

Subscriber's Employer _____

I have been informed of the treatment plan. I authorize release of any information related to this claim.

_____
Signed (Patient, or Parent if Minor) *Date*

I hereby authorize payment directly to the below named dentist of the group insurance benefits otherwise payable to me.

_____
Signed (Insured Person) *Date*

HEALTH HISTORY

Medical History

Please check if patient has, or has had…

YES	NO	
☐	☐	Joint swelling or Arthritis
☐	☐	Bone Disorders
☐	☐	Heart Trouble
☐	☐	Diabetes
☐	☐	Rheumatic Fever
☐	☐	Hepatitis or Liver Problems
☐	☐	Emotional Problems
☐	☐	Tuberculosis
☐	☐	AIDS or HIV
☐	☐	Epilepsy
☐	☐	Prolonged Bleeding
☐	☐	Endocrine Problems
☐	☐	Tonsils removed? If yes, when?_____
☐	☐	Asthma? If so, what medication(s)_____
☐	☐	Adenoids removed? If yes, when?_____
☐	☐	Minor/Major Surgery? If yes, when?_____
☐	☐	Are you currently taking medication?

Dental History

History Update __/__/20__

Please check if patient has, or has had…

YES	NO	
☐	☐	Any injuries to ☐ Face ☐ Mouth ☐ Teeth
☐	☐	Thumb, finger or lip sucking habit(s)? ☐ Continuing ☐ Discontinued
☐	☐	Mouth breathing when ☐ Asleep ☐ Awake
☐	☐	Any known missing permanent teeth?
☐	☐	Any known extra permanent teeth?
☐	☐	Any teeth removed by extraction? When?_____
☐	☐	Is there a tongue thrust problem?
☐	☐	Any clenching or grinding of teeth? ☐ Day ☐ Night ☐ Both
☐	☐	Any pain, popping or locking on opening or closing jaw movement? (Circle)
☐	☐	Frequent headaches? If yes, headaches per week_____ ☐ a.m. ☐ p.m.
☐	☐	Any muscle tenderness or stiffness in the jaw or neck? (Circle)
☐	☐	Any ringing sounds in the ear, or spells of dizziness? (Circle)
☐	☐	Any previous treatment for TMJ or jaw joint problems? If yes, explain_____
☐	☐	Has patient ever been evaluated or had any previous orthodontic treatment? If yes, complete transfer information below.

List any Medication_____ List any Allergies_____

PLEASE LIST YOUR CHIEF CONCERN(S) AND WHAT YOU WOULD LIKE TREATMENT TO ACCOMPLISH_____

To the best of my knowledge the above info is correct

Signature of Patient_____ Signature of Orthodontist_____

Emergency Information

Name of nearest relative not living with you_____

Complete Address_____

Phone ( )_____

A credit check may be obtained from Credit Bureau.

TRANSFER INFORMATION

Previous Orthodontist _____ Last seen_____

Address_____
Street *City* *State* *Zip*

Treatment Started_____ Estimated Treatment Time_____

Records Requested_____/_____/_____ by ☐ mail ☐ phone. Spoke with _____
Month *Day* *Year*
