Bedont ORTHODONTICS
beautiful smiles • life-changing results

1042 NW Norman Ave, Suite 210, Gresham, OR 97030
17470 Shelley Ave, Sandy, OR 97055
1905 SE 192nd Ave, Suite 201, Camas, WA 98607
(503) 665-1115 • (360) 335-3232 • www.bedontortho.com

PATIENT INFORMATION FORM

☐A ☐B ☐C

PERSONAL DETAILS

DATE:_____

Patient's full name:_____ Preferred name:_____ Date of birth: _____

☐ Male ☐ Female Patient's address:_____

Home phone number:_____ Cell phone number: _____

Email address(es) for correspondence/notification:_____

Dentist's name: _____ Doctor's name:_____

Whom may we thank for referring you to our office?_____

IF UNDER THE AGE OF 18

Age: _____School: _____ Musical instruments played:_____

Sports:_____ Hobbies:_____

Sibling names and ages:_____

Father's name:_____ Work phone:_____ Home phone:_____

Mother's name:_____ Work phone: _____ Home phone:_____

Patient lives with:_____

RESPONSIBLE PARTY

Name:_____ Marital status: _____ Spouses name: _____

Relationship to patient: _____ SSN:_____ Date of birth: _____

Employer: _____ Occupation:_____ Number of years employed: _____

Spouse's employer:_____ Occupation: _____ Number of years employed: _____

Residence:_____

Mailing address:_____ How long at this address:_____

Home phone: _____ Work phone: _____ Cell phone: _____

Previous address (if less than 3 years):_____ How long at this address:_____

INSURANCE INFORMATION

Insured name: _____ Date of birth:_____ SSN:_____

Insurance company: _____ ID #: _____ Group #:_____

Insurance Co. address:_____

Insurance Co. phone: _____ Insured employer: _____ Do you have dual coverage? ☐ Yes ☐ No

Co-Insured name: _____ Date of birth:_____ SSN: _____

Insurance company: _____ ID #: _____ Group #:_____

Insurance Co. address:_____

Insurance Co. phone: _____ Insured employer:_____

Patient Name: _____

MEDICAL CHECKLIST

Does the patient have or ever had any of the following medical conditions?

- ☐ Allergies or asthma
- ☐ Arthritis
- ☐ Breathing difficulties
- ☐ Bleeding disorders
- ☐ Bone disorders
- ☐ Cancer or tumor(s)
- ☐ Cleft lip/palate
- ☐ Diabetes
- ☐ Ear infections
- ☐ Endocrine problems
- ☐ Emotional problems
- ☐ Epilepsy or convulsions
- ☐ Fainting or dizziness
- ☐ Hearing problems
- ☐ Heart disease or murmur
- ☐ Hepatitis/liver disease
- ☐ HIV or AIDS
- ☐ Kidney problems
- ☐ Learning disabilities
- ☐ Rheumatic fever
- ☐ Rheumatoid arthritis
- ☐ Sleep apnea/sleep disorders
- ☐ Speech problems
- ☐ TMJ
- ☐ Tuberculosis
- ☐ None

Other medical conditions not listed: _____

MEDICAL HISTORY

☐Y ☐N Does the patient have a health problem? Please list _____

☐Y ☐N Is there a history of serious illness, accident or operation? Please list _____

☐Y ☐N Is the patient under a doctor's care for any problems at this time? Please list _____

☐Y ☐N Is the patient currently taking any medication? Please list _____

☐Y ☐N Has the patient ever taken bisphosphonate medication? Please list _____

☐Y ☐N Does the patient have any allergies or drug sensitivities (latex, penicillin, etc...)? Please list _____

☐Y ☐N Does the patient have frequent headaches? How often? _____

☐Y ☐N Does the patient use tobacco products? _____

DENTAL HISTORY

Date of last dental Exam: _____

☐Y ☐N Has the patient had any injury to the teeth? _____

☐Y ☐N Has the patient had any injury to the face, jaws, or chin? _____

☐Y ☐N Does the patient currently need any dental work to be completed (such as fillings or crowns)? _____

☐Y ☐N Does the patient have any missing, extracted, or extra permanent teeth? _____

☐Y ☐N Does the patient have any pain, clicking, or popping noises in the jaw? _____

☐Y ☐N Does the patient clench or grind their teeth? _____

☐Y ☐N Does the patient suck fingers, thumb, or have a similar habit? _____

☐Y ☐N Has the patient had an orthodontic consultation recently? _____

☐Y ☐N Has the patient had any previous orthodontic treatment? _____

☐Y ☐N Have we treated any other family members? _____

Reason for seeking orthodontic treatment: _____

EMERGENCY INFORMATION

Name of nearest relative not living with you: _____ Phone: _____

Address: _____

SIGNATURE

Patient Signature* *(Parent's signature if minor)* _____ Date: _____

By signing, I agree that the information is true to the best of my knowledge. I have received the Privacy Policies of Bedont Orthodontics. I understand that where appropriate, credit bureau reports may be obtained.