DIPLOMATE
AMERICAN BOARD
OF ORTHODONTICS

American Association of Orthodontists

STUDEBAKER
Orthodontics
ROBERT A. STUDEBAKER, DDS

A B C

Original Date:	
Dates Revised:	

CONFIDENTIAL PATIENT INFORMATION

Name *(First, Middle, Last)*		**Nickname**		**Gender**(*M/F*)	_
Address *(Street, City, State, ZIP)*					
DOB		**Home N umber**		**S.S.N.**	
If a student, attending school		**If a minor, guardian's name accompanying child today**			
How did you hear about our office?					

CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

Name *(First, M iddle., Last)*		**Gender** (*M/F*)	_	**Relationship to patient**	
Residence *(Street, City, State, ZIP)*					
Mailing Address - if different than above:					
How long at this address?		**Previous Address** *(If less than 3 years, Street, City, State, ZIP)*			
DOB:		**Home N umber**		**Cell Number**	
Work Number					
S.S.N.		**e-mail**		**Marital Status**	
Employer		**Occupation**		**Years Employed**	
Spouse Name *(First, Middle, Last)*		**Gender** (*M/F*)	_	**Relationship to Patient**	
DOB		**Cell Number**		**Work Number**	
S.S.N.					
Employer		**Occupation**		**Years Employed**	

DENTAL INSURANCE INFORMATION

Subscriber's Name *(First, M.I., Last)*				**Subscriber's S.S.N.**	
Insurance Company		**Subscriber's ID**		**Group No.**	
Insurance Co. Address *(Street, City, State, ZIP)*				**Insurance Co. Phone No.**	
	DO YOU HAVE DUAL INSURANCE COVERAGE? (*Y/N*)	_			
Subscriber's Name *(First, M.I., Last)*				**Subscriber's S.S.N.**	
Insurance Company		**Subscriber's ID**		**Group No.**	
Insurance Co. Address *(Street, City, State, ZIP)*				**Insurance Co. Phone No.**	

Assignment and Release

I, the undersigned certify that I (or my dependant) have insurance coverage with above insurance carrier (s) and assign directly to Dr. Studebaker all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions. I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor)	
Updates (Date and Initials)	

EMERGENCY INFORMATION

Name of nearest relative not living with you		**Phone No.**	
Complete Address *(Street, City, State, ZIP)*		**Relationship to Patient**	

HEALTH CARE PROVIDER INFORMATION

Patient's Physician:		**Phone Number:**		**Date of last Visit:**	
Patient's Dentist:		**Phone Number:**		**Date of last Visit:**	
Any Other Health Care Provider:		**Phone Number:**		**Date of last Visit:**	

MEDICAL HISTORY QUESTIONNARE

Is patient currently under the care of a physician?	☐ Yes ☐ No	**If yes, physician's name and reason of care:**	
Describe patient's current physical health:	☐Good ☐Fair ☐Poor		
Please list all drugs that patient is currently taking:			
Female Patients only - Age at onset of menstruation:			
Allergies	☐ Latex ☐ Nickel/Metals ☐ Rubella ☐ PABA/Sunscreen ☐ Other:		

Please mark any medical problems patient has experienced	☐ Abnormal Bleeding	☐ Diabetes	☐ Kidney Problems
	☐ ADD/ADHD	☐ Epilepsy	☐ Liver Problems
	☐ AIDS/HIV+	☐ Handicaps/Disabilities	☐ Mitral Valve Prolapse
	☐ Artificial Bones/Joints/Valves	☐ Hearing Impairment	☐ Prosthetics
	☐ Asthma	☐ Heart Murmur	☐ Rheumatic Fever
	☐ Cancer	☐ Hemophilia	☐ Scarlet Fever
	☐ Congenital Heart Defect	☐ Hepatitis	☐ Sickle Cell Disease/Traits
	☐ Convulsions	☐ Hospital Stays/Operations	☐ Tuberculosis (TB)

List any medical condition we have not discussed that you feel we should be aware of:

DENTAL HISTORY QUESTIONNARE

What are the main concerns that you would like orthodontics to accomplish?			
Has patient been evaluated or has had orthodontic treatment before?	☐ Yes ☐ No	**If yes, when and by whom:**	
Does patient require antibiotics before dental treatment?	☐ Yes ☐ No		
Has patient ever experienced any unfavorable reaction to dentistry?	☐ Yes ☐ No		
Has patient ever lost or chipped any teeth?	☐ Yes ☐ No		
Is any part of patient's mouth sensitive to temperature or pressure?	☐ Yes ☐ No		
Do patient's gums bleed when brushing?	☐ Yes ☐ No		
Is patient apprehensive about receiving orthodontic treatment?	☐ Yes ☐ No		
Has anyone on patient's family received orthodontic treatment?	☐ Yes ☐ No	**If yes, who and how did they feel about the result?**	
Does patient have "Tension" headaches?	☐ Yes ☐ No		
Has patient ever experienced chronic ringing in his/her ears?	☐ Yes ☐ No		
Have adenoids or tonsils been removed?	☐ Yes ☐ No		
Does patient have any missing or extra permanent teeth?	☐ Yes ☐ No		
Has patient ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)?	☐ Yes ☐ No		
Does patient brush his/her teeth daily?	☐ Yes ☐ No		
Anything you would like to discuss with Doctor in private?	☐ Yes ☐ No		
Are you aware that some appointments will be during school/work hours?	☐ Yes ☐ No		

Please mark any habits patient may have	☐ Nursing/Bottle Habits	☐ Nail Biting	☐ Tongue Thrust
	☐ Clenching/Grinding teeth	☐ Used Pacifier	☐ Mouth Breather
	☐ Lip Sucking/Biting	☐ Thumb/Finger Sucking	☐ Speech Problems

List any musical instruments played:				
List patient's hobbies, interests and sports played:				
If patient is under 18, height of parents	**Mom's Height:**		**Dad's Height:**	

Patient's Norm: ☐African American ☐American-Indian ☐Asian ☐Caucasian ☐Chinese ☐Japanese ☐Korean ☐Latin ☐South Pacific ☐Other_

List any dental condition we have not discussed that you feel we should be aware of:

BENEFITS OF ORTHODONTICS

Benefits of Orthodontics: Aesthetics, Health and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are in intricate body part and can fail to respond to treatment. If good oral hygiene is not practice, 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 some movement of teeth and some change after treatment. I have read and understand this paragraph; I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Studebaker to perform a complete orthodontic evaluation.

Signature (parent's signature if minor):_____Date:_____