WELCOME
TO THE ORTHODONTIST

We would like to welcome you to our office.
Our goal is to make your visit pleasant and educational.
We strive to teach good oral care that will enable you to have a beautiful smile that lasts a lifetime.

JOSEPH E. JAMISON, DDS, P.A. *1409 MEDICAL CENTER DRIVE • WILMINGTON, NORTH CAROLINA 28401 • TEL: 763-2185*

TELL US ABOUT YOU

Today's Date: _____

Name: _____
LAST FIRST MI

Nickname: _____ Sex: M F

Birthdate: _____ Age: _____

School: _____ Grade: _____

Employer: _____

Hobbies/Sports: _____

Address: _____
APT./CONDO #

_____

_____
CITY STATE ZIP

Work #: _____ Home #: _____

DL#: _____ SS #: _____

General Dentist: _____

Last Visit Date: _____

Other family members treated at this office: (List name and relationship)

_____

_____

_____

Whom may we thank for referring you? _____

_____

PERSON RESPONSIBLE FOR ACCOUNT
(If different from above)

Name: _____ Relation: _____

Birthdate: _____

Billing Address: _____

_____
CITY STATE ZIP

Work #: _____ Home #: _____

Employer: _____

DL#: _____ SS #: _____

Email: _____

PRIMARY ORTHODONTIC INSURANCE

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthday: ___/___/___ & SS#: _____

Insured's Employer: _____

SECONDARY ORTHODONTIC INSURANCE

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthday: ___/___/___ & SS#: _____

Insured's Employer: _____

WHAT ARE THE MAIN CONCERNS THAT YOU WOULD LIKE ORTHODONTICS TO ACCOMPLISH?

_____

_____

_____

Have you ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No

Have there been any injuries to the face, mouth, teeth or chin? ☐ Yes ☐ No

List any musical instruments played _____

Have adenoids or tonsils been removed? ☐ Yes ☐ No

Have you been informed of any extra or missing permanent teeth? ☐ Yes ☐ No

Have you ever had any pain/tenderness in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Do you brush your teeth daily? ☐ Yes ☐ No

Do you floss your teeth daily? ☐ Yes ☐ No

Your Physician: _____

Phone #: _____ Date of Last Visit: _____

Are you currently under the care of a physician? ☐ Yes ☐ No

Please describe your current physical health: ☐ Good ☐ Fair ☐ Poor

Please list all drugs that you are currently taking:

_____

Please list all drugs that you are allergic to:

_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

Y	N		Y	N	
☐	☐	Allergic to Plastic	☐	☐	Allergic to Latex/Metals
☐	☐	Heart Murmur	☐	☐	Congenital Heart Defect
☐	☐	Cancer	☐	☐	Convulsions/Epilepsy
☐	☐	Diabetes	☐	☐	Abnormal Bleeding
☐	☐	Rheumatic Fever	☐	☐	Hearing Impairment
☐	☐	HIV+/AIDS	☐	☐	Any Operations
☐	☐	Hemophilia	☐	☐	Any stays in a hospital
☐	☐	Asthma	☐	☐	Kidney/Liver problems
☐	☐	Hepatitis	☐	☐	Handicaps/Disabilities
☐	☐	Tuberculosis (TB)	☐	☐	Allergies to any drugs.

Please discuss any medical problems that you have had:

_____

_____

_____

_____

DO YOU HAVE ANY OF THE FOLLOWING HABITS?

Y	N		Y	N	
☐	☐	Thumb/Finger Sucking	☐	☐	Mouth Breather
☐	☐	Lip Sucking/Biting	☐	☐	Speech Problems
☐	☐	Clenching/Grinding Teeth	☐	☐	Nail Biting
			☐	☐	Tongue Thrust

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status.

I also authorize the dental staff to perform the necessary dental services I may need.

_____
SIGNATURE OF PATIENT/GUARANTOR DATE

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

_____
SIGNATURE OF PATIENT/GUARANTOR DATE

The Patient/Guarantor is responsible for payment.
Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

F O R O F F I C E U S E O N L Y

I verbally reviewed the medical/dental information above with the patient named herein. Initials _____ Date _____

DOCTOR'S COMMENTS:

_____

_____

_____

_____