



Piper Orthodontics

901-756-4316 PiperOrtho.com

Fred Piper DDS, MS, PC

Specialist in Orthodontics

1. ABOUT YOU

Today's Date: ___/___/___

Name: _____
Last First MR MRS MS DR

I prefer to be called: _____ MI Male Female

Birthdate: ___/___/___ Age: ___ SS#: _____

Home Address: _____
Apt / Condo # _____

City State Zip
 Single Married Divorced Widowed Separated

Hm #: (____) _____ Mobile #: _____

Wk #: (____) _____ Ext. _____ DL#: _____

EMAIL: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best time to reach you? _____

How did you hear about our practice? _____

Referred by Dentist
(If yes, who?) _____

Existing Patient
(If yes, who?) _____

Internet Search

Other _____

General Dentist: _____

Address: _____

Last Visit Date: _____

2. SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

Wk #: (____) _____ Ext. _____ SS#: _____

Birthdate: ___/___/___

Person Responsible for Account: _____

Wk #: _____ Ext. _____ Hm #: _____

Billing Address: _____

Relation: _____ SS#: _____

Employer: _____

3. ORTHODONTIC INSURANCE

Primary Insurance:

Orthodontic Coverage? Yes No Dental Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

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

Insured's Name: _____ Relation: _____

Address: _____ Phone #: _____

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

Insured's Employer: _____

Secondary Insurance:

Orthodontic Coverage? Yes No Dental Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

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

Insured's Name: _____ Relation: _____

Address: _____ Phone #: _____

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

Insured's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: _____ Relation: _____

Wk #: (____) _____ Hm #: (____) _____

CONTINUED ON BACK

4. DENTAL HISTORY

What are the main concerns that you would like orthodontics to address? _____

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

Have you ever had a serious / difficult problem associated with any previous dental work? Yes No

Do you now or have you ever experienced pain/ discomfort in your jaw joint (TMJ / TMD)? Yes No

Your current dental health is: Good Fair Poor

Do you like your smile? Yes No

Gums ever bleed? Yes No

Have you ever had an injury to your: Mouth Teeth Chin (please circle)

Do you have any speech problems? _____

Do you generally breathe through you mouth? Yes No

If yes, please circle: While Awake? While Asleep?

Do you have any missing or extra permanent teeth? Yes No

Do you clench or grind teeth? Yes No

If yes, when? _____

5. MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: _____

Phone #: (_____) _____ Date of last visit: _____

6. MEDICAL HISTORY (continued)

Your current physical health is: Good Fair Poor

Are you taking any prescription / over-the-counter drugs? Yes No

Please list each one: _____

For Women:

Are you pregnant? Yes No Week #: _____

Have you ever had any of the following diseases or medical problems?

- | | |
|----------------------------------------|----------------------------------|
| Y N Abnormal Bleeding | Y N Heart Murmur |
| Y N Anemia | Y N Heart Surgery / Pacemaker |
| Y N Artificial Bones / Joints / Valves | Y N Hemophilia |
| Y N Arthritis | Y N Hepatitis |
| Y N Asthma | Y N High / Low Blood Pressure |
| Y N Blood Transfusion | Y N HIV+ / AIDS |
| Y N Cancer / Chemotherapy | Y N Kidney Problems |
| Y N Congenital Heart Defect | Y N Mitral Valve Prolapse |
| Y N Diabetes | Y N Radiation Treatment |
| Y N Difficulty Breathing | Y N Rheumatic / Scarlet Fever |
| Y N Drug / Alcohol Abuse | Y N Severe / Frequent Headaches |
| Y N Emphysema | Y N Shingles |
| Y N Epilepsy / Seizures / Fainting | Y N Sickle Cell Disease / Traits |
| Y N Fever Blisters / Herpes | Y N Sinus Problems |
| Y N Glaucoma | Y N Tuberculosis (TB) |
| Y N Heart Attack / Stroke | Y N Ulcers / Colitis |

Please list any serious medical condition(s) that you have ever had: _____

Are you allergic to any of the following:

- | | | |
|-------------------------|------------------------|------------------|
| Y N Aspirin | Y N Dental Anesthetics | Y N Penicillin |
| Y N Any Metals/Plastics | Y N Erythromycin | Y N Tetracycline |
| Y N Codeine | Y N Latex | Y N Other |

Please list any other drugs / materials that you are allergic to: _____

THANK YOU FOR FILLING OUT THIS FORM COMPLETELY.

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.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

Signature

Date

Signature

Date

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

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I verbally reviewed the medical / dental information above with the parent / guardian and patient name herein.

Initials: _____ Date: _____

Doctor's Comments: _____

