michael teichman
mto
orthodontics

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

Name: _____ Birthdate: _____ ☐ Male ☐ Female
First MI Last Preferred Nickname?

Address: _____ Telephone Home: (____) _____
Street / City / ZIP

Social Security No.: _____ Telephone Cell: (____) _____

Email: _____

Please list name(s) of other people in your family who have seen Dr. Teichman: _____

Person(s) responsible for account: Name(s): _____

Address: _____

Why did you seek this consultation? _____

What is the primary problem? _____

Additional comments you wish to make? _____

YOUR INFORMATION

☐ Married
☐ Divorced
☐ Single
☐ Domestic Partner

Employer: _____ Telephone: (____) _____
Business Name Union Name Local #

Dental Insurance Co.: _____ Group #: _____

Address: _____ Telephone: (____) _____
Street / City / ZIP

Social Security No.: _____ Birthdate:

Spouse Information

Name: _____

☐ Married
☐ Divorced
☐ Single
☐ Domestic Partner

Address: _____ Telephone: (____) _____
Street / City / ZIP

Employer: _____ Telephone: (____) _____
Business Name Union Name Local #

Dental Insurance Co.: _____ Group #: _____

Address: _____ Telephone: (____) _____
Street / City / State / ZIP

Social Security No.: _____ Birthdate: _____

FOR BILLING PURPOSES:
I hereby authorize Dr. Teichman to use my signature on file for insurance billing purposes, and futher authorize payment of insurance benefits, otherwise payable to me, directly to him. Where appropriate, credit reports may be obtained.

Signed _____
Patient (or Parent if Patient is a Minor)

OTHER DENTAL INSURANCE

Name of Insured: _____ Employer: _____

Address: _____ Dental Insurance Co.: _____

SS #: _____ Birthdate: _____ Address: _____

Relationship to You: _____ Tel. No. (____) _____ Group #: _____

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent. 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 the office, use the services of one or more credit reporting services.

Signature _____ **Date** _____

— PLEASE COMPLETE REVERSE SIDE —

Whom can we thank for referring you? _____

1. Are you currently under medical treatment? Describe: _____ ☐ Yes ☐ No
2. Are you currently taking any medication? List: _____ ☐ Yes ☐ No
3. Are you currently taking any Bishoshonate (Fosomax Ect...) ? _____ ☐ Yes ☐ No
4. Who is your physician? Name & Phone: _____
5. Do you have a history of any of the following:

Allergies: ☐ Plastic ☐ Metals ☐ Latex ☐ Erythromycin ☐ Penicillin

List any others: _____

Heart Trouble / Defects / Murmur / Attack / Surgery Describe: _____ Pre-Meds? ☐ Yes ☐ No

Artificial Bones / Joints / Valves Describe: _____ Pre-Meds? ☐ Yes ☐ No

Physical and/or Mental Limitations Describe: _____

Abnormal Bleeding	☐ Yes	☐ No	Frequent Headaches	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
ADD/ADHD	☐ Yes	☐ No	Gag Reflex	☐ Yes	☐ No	Phobias	☐ Yes	☐ No
Alcohol/Drub Abuse	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Pregnant	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Psychiatric Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Hearing Difficulties	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Rheumatic/Scarlet Fever	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	School Problems	☐ Yes	☐ No
Cancer/Chemo	☐ Yes	☐ No	Herpes/Fever Blisters	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Colitis	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Shingles	☐ Yes	☐ No
Delayed Development	☐ Yes	☐ No	High Fevers	☐ Yes	☐ No	Sickle Cell Anemia	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	HIV/AIDS	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No
Difficulty Breathing	☐ Yes	☐ No	Hospitalization (any)	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Emotional Problems	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	TMD/TMJ/Clicking	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tuberculosis (TB)	☐ Yes	☐ No
Fainting Spells	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
			Motion Sickness	☐ Yes	☐ No			

Explanation of question(s) answered Yes: _____

_____

_____

6. Last dental visit was: Date _____ Dr. _____ Phone _____
7. Have there been any unfavorable dental experiences? Describe: _____ ☐ Yes ☐ No
8. Do you have any of the following habits? If not presently, at what age did the habit stop? _____

Thumb/Finger Sucking	☐ Yes	☐ No	Lip Sucking	☐ Yes	☐ No	Grinding/Clenching	☐ Yes	☐ No
Tongue Thrust	☐ Yes	☐ No	Nail Biting	☐ Yes	☐ No	Mouth Breathing	☐ Yes	☐ No

9. Have there been any injuries to teeth? Describe: _____ ☐ Yes ☐ No
10. Family dental history:
    Have you had a previous orthodontic consultation or treatment? Date _____ Dr. _____
11. Any additional information about you we should know? _____

_____

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

I DO HEREBY AUTHORIZE SUCH DENTAL CARE THE JUDGMENT OF THE DENTIST MAY DICTATE.

• FOR OFFICE USE ONLY • MEDICAL HISTORY UPDATE • FOR OFFICE USE ONLY • MEDICAL HISTORY UPDATE •

Date _____ Changes _____ Initials _____

Date _____ Changes _____ Initials _____

Date _____ Changes _____ Initials _____