# Welcome to Myser Orthodontics

Scott A. Myser, D.D.S., M.S., P.A.

## Patient Information

Patient Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Birth Date _____ SS# _____ Age _____
How did you hear about our office? _____ Patient's Dentist _____

## Responsible Party Information

**Responsible Party's Name** _____ Relationship to Patient _____
Mailing Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____
Email _____ Previous Address (if less than 3 years) _____
SS# _____ Birth Date _____ Drivers License # _____
Employer _____ Number of years _____
Employer's Address _____ Occupation _____

**Father/Guardian Name** _____
Mailing Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____
SS# _____ Birth Date _____ Drivers License # _____
Employer _____ Number of years _____
Employer's Address _____ Occupation _____

**Mother/Guardian Name** _____
Mailing Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____
SS# _____ Birth Date _____ Drivers License # _____
Employer _____ Number of years _____
Employer's Address _____ Occupation _____

**Siblings (Name/Age)** _____

## Insurance Information

**Insured's Name** _____ Birth Date _____ SS# _____
Dental Insurance Company _____ Policy # _____ Group # _____
Insurance Company Address _____
Insurance Company Phone _____ Insured's Employer _____
Secondary Insurance Company _____ Insured's SS# _____
Secondary Insurance Company Address _____
Secondary Insured's Employer _____

## Emergency Information

Emergency Contact (other than guardian) _____
Relationship _____ Daytime Phone _____ Alternate Ph. _____

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I certify that all of the above information is true and it is my responsibility to inform this office of any changes, and that in order to receive complete information on financial options it is necessary for me to authorize a credit report.

**Signature** (Guardian's signature if a minor) _____ Relationship _____ Date _____

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## Health History

Initial Date _____ Update 1 _____ Update 2 _____

### MEDICAL HISTORY

*Please check Yes or No if the patient has or has ever had...*

| Y | N | |
|---|---|---|
| | | Joint Swelling or Arthritis |
| | | Bone Disorders |
| | | Heart Problems |
| | | Diabetes |
| | | Thyroid Problems |
| | | Kidney Problems |
| | | Rheumatic Fever |
| | | Hepatitis or Liver Problems |
| | | Emotional Problems |
| | | Tuberculosis |
| | | AIDS / HIV |
| | | Anemia |
| | | Asthma |
| | | Epilepsy |
| | | Prolonged Bleeding |
| | | Endocrine Problems |
| | | Tonsils Removed |
| | | Adenoids Removed |

Please list dates and specifics for all "Yes" answers:

List any allergies:

List any medications presently being taken:

List any serious illness or operation not listed above:

Is the Patient currently under a physician's care? _____
Physician's Name _____
Reason _____

### DENTAL HISTORY

Chief complaint: _____

*Please check Yes or No if the patient has or has ever had...*

| Y | N | |
|---|---|---|
| | | Any injury to face, mouth, teeth? |
| | | Thumb, finger or lip sucking habit(s)? |
| | | Any speech problems? |
| | | Mouth breathing when asleep, awake? |
| | | Any known missing permanent teeth? |
| | | Any known extra permanent teeth? |
| | | Any teeth removed by extraction? |
| | | Tongue thrust? |
| | | Any wind instruments played? |
| | | Clenching or grinding of teeth? |
| | | Chronically sore or bleeding gums? |
| | | Jaw pain, popping, grinding, locking? |
| | | Difficulty chewing or swallowing food? |
| | | Frequent headaches? |
| | | Muscle tenderness or stiffness in neck/jaw? |
| | | Ringing of ear, dizziness? |
| | | Previous treatment for TMJ or joint problems? |

Please list dates and specifics for all "Yes" answers:

Does patient visit dentist regularly? _____
Has an orthodontist been consulted previously?
Reason: _____
Has patient experienced a sudden increase in height?_____
Does any member of the family or close relative(s) have a similar arrangement of the teeth or similar appearance of the jaws? Explain:

Please list any other dental information known, and not listed above.

The above information is true to the best of my knowledge, and I understand that it is my obligation to update this information as changes become known to me.

**Patient/Parent/Guardian Signature** _____ **Date** _____