CARR
ORTHODONTICS

WELCOME

2755 Esplanade, Chico, CA 95973 · Phone: (530) 343-7021

The benefits of a happy, healthy smile are immeasurable!
Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely.
The better we communicate, the better we can care for you.

Today's Date _____

1 ABOUT YOU

Name _____

Preferred Name _____ ❑ M ❑ F ❑ N

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Birthdate ___/___/___ Age____ SS# ___-___-_____

Address _____

City _____ State _____ Zip _____

E-mail _____

Home # _____ Work # _____

Cell # _____ DL # _____

General Dentist: _____

Last visit date _____

Other family members seen by us? _____

Employer _____

Employer Address _____

Who can we thank for referring you to us?
(i.e friend/family, dentist, online, etc.) _____

2 ACCOUNT INFO

PERSON RESPONSIBLE FOR ACCOUNT

Name _____ Relation _____

Home # _____ Work # _____

Cell # _____ Birthdate ___/___/___

E-mail _____

Billing Address _____

City _____ State _____ Zip _____

3 SPOUSE INFO

Name _____

Home # _____ Work # _____

Cell # _____ Birthdate ___/___/___

E-mail _____

4 PRIMARY ORTHODONTIC INSURANCE

Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # _____

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

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birth Date _____ SS # _____

Policy Owner's Employer _____

SECONDARY ORTHODONTIC INSURANCE

Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # _____

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

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birth Date _____ SS # _____

Policy Owner's Employer _____

5a MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name _____

Phone # _____ Last visit date _____

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

Please explain _____

IN THE EVENT OF AN EMERGENCY
WHO SHOULD WE CONTACT?

Name _____ Relation _____

Home # _____ Work # _____

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5b MEDICAL HISTORY

Your current physical condition ❑ Good ❑ Fair ❑ Poor

Do you smoke or use tobacco in any form? ❑ Yes ❑ No

Are you taking any prescription/over-the-counter or herbal supplement drugs? ❑ Yes ❑ No

Please list each one _____

_____

_____

Do you take or have taken medication for osteoporosis or metastic bone cancer? ❑ Yes ❑ No

FOR WOMEN ONLY

Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Week # _____

Are you nursing? ❑ Yes ❑ No

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASE OR MEDICAL PROBLEMS?

Yes	No	Abnormal Bleeding	Yes	No	Herpes / Fever Blisters
Yes	No	Alcohol / Drug Abuse	Yes	No	High Blood Pressure
Yes	No	Arthritis	Yes	No	HIV + / AIDS
Yes	No	Artificial Bones, Joints, Valves, or Implants	Yes	No	Hospitalized for any reason
Yes	No	Asthma	Yes	No	Kidney Problems
Yes	No	Cancer / Chemotherapy	Yes	No	Liver Disease
Yes	No	Congenital Heart Defect	Yes	No	Lupus
Yes	No	Diabetes	Yes	No	Mitral Valve Prolapse
Yes	No	Difficulty Breathing	Yes	No	Pacemaker
Yes	No	Emphysema	Yes	No	Psychiatric Problems
Yes	No	Epilepsy	Yes	No	Radiation Treatment
Yes	No	Fainting Spells	Yes	No	Rheumatic / Scarlet Fever
Yes	No	Frequent Headaches			
Yes	No	Glaucoma	Yes	No	Seizures
Yes	No	Heart Attack	Yes	No	Sinus Problems
Yes	No	Heart Murmur	Yes	No	Stroke
Yes	No	Heart Surgery	Yes	No	Thyroid Problems
Yes	No	Hemophilia	Yes	No	Tuberculosis (TB)
Yes	No	Hepatitis	Yes	No	Ulcers

Please list other medical condition(s) that you have ever had

_____

_____

PLEASE LIST ALL DRUGS / MATERIALS THAT YOU ARE ALLERGIC TO:

_____

_____

_____

_____

_____

6 DENTAL HISTORY

Has your doctor told you that you require antibiotics before dental treatment? ❑ Yes ❑ No

Are you currently in pain? ❑ Yes ❑ No

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

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

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Do your gums ever bleed? ❑ Yes ❑ No

Do you like your smile? ❑ Yes ❑ No

If you could change anything about your smile, what would it be?

_____

_____

_____

_____

7 DISCLAIMER

I understand that information I have given today is correct to the best of my knowledge. I also understand 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. 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. I hereby authorize payment of the group insurance benefits directly to this office.

_____

Signature Date

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

CARR ORTHODONTICS

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

❑ Please check here if you would like a copy of your HIPAA privacy policy.

OFFICE USE ONLY

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

Doctor's comments: _____

_____

_____

_____