KRIGER ORTHODONTICS

ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS FOR CHILDREN AND ADULTS
Maryann Kriger, DDS, P.A.

BONITA LOCATION
27970 Crown Lake Boulevard, Suite 2
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Date:_____

Patient's Last Name | Patients' First Name | Patient Prefers to be Called | Gender M/F

Patient's DOB | Patient's Age | Patient's E-Mail Address

Patient's Street Address | City, Zip Code | Patient's Home # | Patient's Cell #

If patient is a minor, give parent's or guardian's name: _____

How did you hear about us? 1) Dentist Name: _____2)Friend's Name:_____
3)Google/online:_____4)Event:_____ 5) Direct Mail:_____ 6) Yellow Pages:____ 7) Insurance Plan:_____

Are other family members treated here? Yes ☐ / No ☐ If so, who? _____

Sibling/Children information:

Sibling/Child Full Name | M/F | Sibling/Child DOB | Sibling/Child Full Name | M/F | Sibling/Child DOB

Sibling/Child Full Name | M/F | Sibling/Child DOB | Sibling/Child Full Name | M/F | Sibling/Child DOB

RESPONSIBLE PARTY INFORMATION

Resp. Party's Last Name: | First Name | E-mail Address | Relationship to Pt

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐

Resp. Party's Street Address | City, Zip Code | Home # | Work # | Cell #

How long at this address? _____

Resp. Party's Employer | Resp. Party's Occupation | # Yrs at Employer | Resp. Party's DOB

Previous Address if less than 3 yrs at current residence:

Previous Street Address | Previous City | State | Zip code

Spouse/Partner | Relationship to Patient | Occupation | # Yrs at Employer | Spouse/Partner DOB

Spouse/Partner Work # | Spouse/Partner Cell # | Spouse/Partner E-Mail Address

PRIMARY ORTHODONTIC INSURANCE INFORMATION

Insured's Name | Insurance Co. Name | Insured's ID# | Insured's Group #

Do you have dual insurance coverage? Yes ☐/ No ☐

SECONDARY ORTHODONTIC INSURANCE INFORMATION

Insured's Last Name | First Name | Insurance Co. Name | Insured's ID# | Insured's Group #

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Patient's Name | Patient's Dentist | Last Dental Visit

Orthodontic

Has an orthodontist been previously consulted? ☐ yes ☐ no
In your own words, describe your orthodontic problems and what would you like orthodontics to accomplish?
Indicate the patient's feelings toward orthodontic treatment? ☐ eager to get started ☐ complacent ☐ not committed to cooperate
Hobbies/Comments:

Dental

What was your dentist's main concern?
Is there any dental work that needs to be completed prior to orthodontic treatment? ☐ yes ☐ no
Are antibiotics necessary for teeth cleanings? ☐ yes ☐ no **If yes- do you take Penicillin or Clindamycin?**
What was the date of your last cleaning?

Medical

Physician's Name: **Last physical exam:**
Is under the care of a physician at this time? ☐ yes ☐ no **If yes, please explain reason for physician's care:**
List any medications being taken at this time: **Has currently or previously taken bisphosphonates?** ☐ yes ☐ no
List any drugs/things that is allergic to or has a reaction to:

Please check yes or no if currently has or has had:

Abnormal Adenoids/Tonsils	☐ yes ☐ no	Endocrine problems	☐ yes ☐ no	Osteoporosis	☐ yes ☐ no
AIDS/HIV	☐ yes ☐ no	Epilepsy	☐ yes ☐ no	Prolonged bleeding	☐ yes ☐ no
Allergy/Sinus trouble	☐ yes ☐ no	Faintness/Dizziness	☐ yes ☐ no	Psychiatric treatment	☐ yes ☐ no
Anemia Epilepsy/Convulsions	☐ yes ☐ no	Fever blisters	☐ yes ☐ no	Rad/Chemo/Blood therapy	☐ yes ☐ no
Arthritis/Thyroid problems	☐ yes ☐ no	Headaches (frequent)	☐ yes ☐ no	Respiratory problems	☐ yes ☐ no
Artificial heart valves	☐ yes ☐ no	Heart murmur	☐ yes ☐ no	Rheumatic/Scarlet/Yellow fever	☐ yes ☐ no
Asthma	☐ yes ☐ no	Heart trouble	☐ yes ☐ no	Scoliosis	☐ yes ☐ no
Bone disorders	☐ yes ☐ no	Finger/Thumb/Lip sucking	☐ yes ☐ no	Shortness of breath	☐ yes ☐ no
Blood disease	☐ yes ☐ no	Hemophiliac	☐ yes ☐ no	Stroke	☐ yes ☐ no
Bruxing/Grinding	☐ yes ☐ no	Hepatitis	☐ yes ☐ no	TMJ problems	☐ yes ☐ no
Cancer	☐ yes ☐ no	Herpes	☐ yes ☐ no	Thyroid problems	☐ yes ☐ no
Cardiac pacemaker	☐ yes ☐ no	High/Low Blood pressure	☐ yes ☐ no	Tonsils removed	☐ yes ☐ no
Congenital heart lesions	☐ yes ☐ no	Jaundice	☐ yes ☐ no	Tuberculosis	☐ yes ☐ no
Chronic cough	☐ yes ☐ no	Joint swelling	☐ yes ☐ no	Disabilities	☐ yes ☐ no
Diabetes	☐ yes ☐ no	Kidney disease	☐ yes ☐ no	Venereal disease	☐ yes ☐ no
Drug addiction	☐ yes ☐ no	Liver disease	☐ yes ☐ no	Wound healing problems	☐ yes ☐ no
Ear problems	☐ yes ☐ no	Organ transplant	☐ yes ☐ no	Whiplash	☐ yes ☐ no
Emotional problems	☐ yes ☐ no	Muscle or joint disorder	☐ yes ☐ no		
Is the patient pregnant?	☐ yes ☐ no	Is bite uncomfortable?	☐ yes ☐ no	Cheek, tongue or lip chewing?	☐ yes ☐ no
Has patient reached puberty?	☐ yes ☐ no	Jaw symptoms/headaches?	☐ yes ☐ no	Clenching teeth?	☐ yes ☐ no
Any facial injuries?	☐ yes ☐ no	Trauma to the jaw?	☐ yes ☐ no	Grinding teeth?	☐ yes ☐ no
Mouth breathing?	☐ yes ☐ no	Does the patient smoke?	☐ yes ☐ no	Fingernail habit?	☐ yes ☐ no
Missing/extra permanent teeth?	☐ yes ☐ no	Abnormal height or weight?	☐ yes ☐ no	Thumb sucking habit? Till what age:_____	
Speech problems?	☐ yes ☐ no	Adopted? Does he/she know?	☐ yes ☐ no	Pacifier used? Till what age_____	
Pain/clicking upon opening mouth?	☐ yes ☐ no	Latex allergy?	☐ yes ☐ no		

Please explain ANY Diseases, Medical or Dental Conditions that are not mentioned above:

CONSENT: The undersigned hereby authorizes the doctor to take x-rays, study models, photographs in order to make a thorough diagnosis of the patient's orthodontic needs. It is my responsibility to inform this office immediately of any changes in medical status. I have read and understand each question and have answered all of them truthfully and to the best of my ability. I understand that when appropriate; credit bureau reports may be obtained.

Signature (Parent's signature if minor) | Date

Emergency Contact | Phone #

Clear Print Save