KRIGER ORTHODONTICS
Dr. Maryann Kriger, DDS, P.A.
Board Certified Orthodontist

ORTHODONTICS & ALIGNERS FOR ALL AGES

BONITA SPRINGS
27970 Crown Lake Blvd.
Bonita Springs, FL 34135
947-1235

MARCO ISLAND
987 North Collier Blvd.
Marco Island, FL 34145
394-1236

FORT MYERS
7780 Cambridge Manor Pl.
Fort Myers, FL 33907
689-5515

WEBSITE: BonitaOrtho.com | EMAIL: BonitaOrtho@live.com | FAX: 949-2099

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 Occupat ion | # 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:

Las t 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	
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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 #