Bemidji ORTHODONTICS
BRET E. COOPER, DDS MS

Welcome to our office! In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. You can either print out this form or click submit and it will place into an e-mail for you. Some fields are required. Thank you for your cooperation!

Patient Information

Last Name _____ First Name _____ Middle _____

I prefer to be called (Nickname) _____ Gender: ○ Male ○ Female

Birth date (MM-DD-YYYY) _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell/Other Phone _____

Email _____ Other Family Members Seen By Us _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

Responsible Party Last Name _____ First Name _____

Mailing Address _____ City _____ State _____ Zip _____

Home Ph. _____ Work Ph. _____ Cell Ph. _____

Birth date (MM-DD-YYYY) _____ Social Security # _____ Email _____

Relationship to Patient _____ Employer _____

Occupation _____

Spouse's Last Name _____ First Name _____

Address (if different) _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell/Other Phone _____

Birth date (MM-DD-YYYY) _____ Social Security # _____ Email _____

Relationship to Patient _____ Employer _____

Occupation _____

Emergency Information

Who should we notify in case of emergency _____ Phone _____

Relationship to Patient _____

Dental Insurance Information

Primary Policy Holder's Name_____ Social Security #_____

Insurance Company _____ Group #_____ Insurance ID # _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer_____

Do you have dual coverage? ○ Yes ○ No (If yes, please fill out the Secondary Policy Information below)

Secondary Policy Holder's Name _____ Social Security # _____

Insurance Company _____ Group # _____ Union Local # _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer_____

Medical History

Physician _____ Phone_____ Date of Last Visit_____

Address _____

Please fill out the following fields and elaborate as necessary.

○ Yes ○ No Is there a current medical problem? _____

○ Yes ○ No Is the patient taking any pills, medications, or drugs? _____

○ Yes ○ No Is the patient allergic to any medications or anesthetics? _____

○ Yes ○ No Is the patient allergic to latex?

○ Yes ○ No Is the patient allergic to anything else?_____

○ Yes ○ No Has the patient had a serious illness? _____

○ Yes ○ No Has the patient had any surgery or been hospitalized? _____

○ Yes ○ No Has the patient ever had an injury to the head, face, or mouth? _____

○ Yes ○ No Has the patient's tonsils and/or adenoids been removed?_____

○ Yes ○ No Does the patient snore? _____

○ Yes ○ No Is the patient sleepy during the day? _____

Please check any of the following conditions the patient has had or currently has

- ☐ Abnormal/Prolonged Bleeding
- ☐ Anemia/Blood Disease
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy/Seizures
- ☐ Heart Problems
- ☐ Heart Murmur
- ☐ Pneumonia
- ☐ Nervousness/Anxiety
- ☐ Radiation/Chemotherapy
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Tumor or other growths
- ☐ Stomach Ulcers
- ☐ Tonsillitis
- ☐ Herpes
- ☐ HIV/AIDS
- ☐ Kidney Problems
- ☐ Psychiatric Care
- ☐ Immune System Problems
- ☐ High Blood Pressure
- ☐ Sinus Trouble
- ☐ Fainting
- ☐ Bone Disorders
- ☐ Thyroid/Parathyroid Problems
- ☐ Endocrine Problems
- ☐ Frequent Headaches
- ☐ Hepatitis/Liver Problems
- ☐ Gastrointestinal Disorders

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

_____

Dental History

Who is the patient's dentist? _____

When was the patient last seen by a dentist? _____

What was the reason for the visit? _____

Has any member of the family had orthodontic treatment? _____

What are your main concerns about your teeth and what would you like orthodontics to accomplish? _____

_____

Has the patient:

Yes No Had trouble associated with dental treatment? _____

Yes No Had a previous orthodontic treatment or consultation? _____

With whom? _____ When _____

Yes No Had any teeth extracted? Why? _____

Yes No Ever injured or broken any teeth? When/what happened? _____

Yes No Ever injured the head or face? When/what happened? _____

Yes No Had any problems with eating, chewing, or swallowing? _____

Yes No Ever sucked ❑ thumb ❑ fingers ❑ bit nails? Until what age? _____

Yes No Dental or facial pain? _____

Yes No Jaw joints make a noise when opening/closing? _____

Yes No Jaw joints cause pain? _____

Yes No Teeth or jaws feel uncomfortable when you awake in the morning? _____

Yes No Clench or grind teeth? _____

Yes No Tension headaches? _____

Yes No Speech problems? _____

Yes No Normally breathe with lips parted? _____

Yes No Swellings or growths in mouth or face? _____

Yes No Had/has periodontal (gum) disease?

Yes No Any negative or resistant feelings about orthodontic treatment? _____

Yes No Dissatisfied with appearance of the teeth? _____

Yes No Specifically resistant to: ❑ Braces ❑ Headgear ❑ Retainers

Yes No Is there any other information we should know? _____

I understand that the information that I have provided is correct to the best of my knowledge, 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, dental, or insurance status. 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 authorized the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office. I understand that where appropriate, credit bureau reports may be obtained for the purpose of considering payment options.

Responsible Party Signature _____ Date _____

You will be asked to sign the form at your appointment.

Spouse Signature (if dual coverage) _____ Date _____

SUBMIT FORM

How did you find us?

❑ Online Search ❑ Phonebook ❑ Friend/Family ❑ Dentist

❑ Other _____