



Frank R. Marshall, DDS MS

Specialized Orthodontic Care for Children, Adolescents & Adults

Patient Information

Name Address Birthdate Home Phone Employer General Dentist Whom may we thank for referring you to our office

Spouse / Additional Contact Information

Name Address Birthdate Home Phone Employer Occupation No. Years Employed

Insurance Information

Policy Owner's Name Policy Owner's Social Security # Policy Owner's Birthdate Relationship to Patient Policy Owner's Employer Employer's Address Insurance Company Group No. Insurance Co. Address Insurance Phone No.

Secondary Insurance

Policy Owner's Name Policy Owner's Social Security # Policy Owner's Birthdate Relationship to Patient Policy Owner's Employer Employer's Address Insurance Company Group No. Insurance Co. Address Insurance Phone No.

Medical History

Are you under the care of a physician? Yes No If Yes, explain _____

Physician _____ Phone _____ Last Visit _____

Address _____

Are you pregnant Yes No If so how many weeks _____

What are the main concerns that you would like orthodontics to accomplish? _____

Have you ever been evaluated for orthodontic treatment? Yes No

Have your tonsils or adenoids been removed? Yes No

Have you ever experienced jaw joint pain/ discomfort (TMJ/TMD)? Yes No

Do you have any missing or extra permanent teeth? Yes No

Have you ever had an injury to : (select all that apply) Teeth Mouth Chin

Do you have speech problems? Yes No if Yes, explain _____

Do your gums bleed? Yes No Do you smoke? Yes No Do you like your smile? Yes No

Do/Have you have/had any of the following habits?

<input type="checkbox"/> Lip Sucking/Biting	<input type="checkbox"/> Nail biting	<input type="checkbox"/> Prolonged Bottle/Pacifier	
<input type="checkbox"/> Clenching/Grinding Teeth	<input type="checkbox"/> Mouth Breather	<input type="checkbox"/> Tongue Thrusting	<input type="checkbox"/> Thumb/ Finger Sucking

Are you allergic to any of the following?

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Erythromycin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Any Metals/Plastics | |

Other Allergies/Sensitivities:

List all drugs you are currently taking

List any serious medical condition(s) treated

Signature

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 confidences and it is my responsibility to inform this office of any changes in my medical status.

I hereby authorize 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.

Name of person filling out this form _____ Date _____