Grand Rapids Orthodontics

615 NE 4th St – (218) 999-5588

Date_____ Dentist _____ Referred by _____

1

Patient information

Patient Name_____

Address_____ City_____ State_____ Zip_____

Birth date_____ ❒ Male ❒ Female

Cell phone _____ Home phone _____

Employer Name _____ Occupation/Title _____

Work Phone _____ Social Security Number _____

Email Address: _____

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Dental Insurance – This must be filled out completely

❒ None ❒ Company Name _____

Address of Insurance Company_____

Phone Number of Insurance Company _____ Group number_____

Subscriber Name _____ ID number_____

Employer _____ Social Security Number _____

Address of Subscriber _____ City _____State_____ Zip_____

Phone number_____ Birthdate _____

Relationship to patient _____

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I give my permission to Dr. Mueller and his staff to obtain diagnostic records in the way of clinical exams, radiographs (x-rays), impressions, and photographs necessary in the determination of treatment to be rendered. I further agree to authorize the release of these records and/or duplicates to my insurance carrier should they be requested. I understand that there may be a charge for record duplication should my insurance carrier so request. Should I decide not to proceed with the proposed treatment, I understand that there will be a charge for the records. This cost will be included as part of the total treatment fee should I elect to accept the proposed treatment. I have reviewed the above statement and been given the opportunity to ask questions about any and all portions that are unclear. I agree to the above statements.

I authorize and request my insurance company to pay directly to Dr. Mueller any insurance benefits otherwise payable to me. I authorize the doctors to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

Signature_____ **Date**_____

Dental History

Current Dentist_____ Date of last exam/cleaning_____

Have you experienced any of the following?

Bleeding gums	y n	Frequent headache	y n	Jaw joint pain	y n
Jaw joint noises	y n	Clenching or grinding	y n	Toothaches	y n
Head/neck injuries	y n	Dental/facial pain	y n	Jaw fractures	y n
Orthodontic treatment	y n	Oral surgery	y n	Gum treatment	y n
Bite adjustment	y n	Splint therapy	y n		

Have you ever had teeth knocked out or fractured? Y N _____

Have you ever had a negative experience in a dental office? Y N _____

What would you like to see different about your teeth/smile? _____

_____

Has another orthodontist been consulted? Y N _____

Medical History

Current Physician_____ Date of last physical exam_____

Have you ever had any of the following conditions>

Anemia	y n	Heart trouble	y n	Sinus problems	y n
Hepatitis	y n	High blood pressure	y n	Eating disorder	y n
Glaucoma	y n	Respiratory disease	y n	Mental disorder	y n
Arthritis	y n	Rheumatic fever	y n	Medical transplants	y n
Diabetes	y n	Chemical dependency	y n	Radiation therapy	y n
Tonsillitis	y n	Epilepsy	y n	Chemotherapy	y n
Allergies	y n	Medical allergies	y n	Speech therapy	y n
Asthma	y n	AIDS or ARC	y n	Bleeding disorders	y n

If yes, please explain _____

Are you currently taking any medications? Y N If yes, please list _____

Women: are you pregnant or suspect that you might be pregnant? Y N

Please list any additional medical conditions _____

I, the undersigned, have provided the above information, have reviewed it and find it accurate. If there are any changes in the information provided, I will inform this practice prior to the continuation of treatment.

Signature _____ Date _____