Designing smiles that last a lifetime.

Dr. Ashley L. Reynolds
CRESCENT ORTHODONTICS PLLC

PATIENT INFORMATION FOR PATIENTS OVER 18 YEARS OF AGE

1 About You

Date _____

Patient's Name _____
LAST FIRST MI

Address _____
APT/CONDO #

_____
CITY STATE ZIP

Email _____ Nickname _____

☐ Male ☐ Female Birthdate _____ Age _____

SSN _____ Driver's License _____

Home # _____ Mobile _____

Work # _____ Ext _____

EMPLOYER _____

Employer's Address _____

Occupation _____

Whom may we thank for referring you? _____

Other family members seen by us _____

General Dentist _____ Date of Last Visit _____

2 Spouse Information

His / Her Name _____

Employer _____

Work # _____ Ext _____

Birthdate _____ SSN _____

3 Person Responsible for Account

His / Her Name _____

Work # _____ Ext _____

Home # _____ SSN _____

Relation _____ Driver's License _____

Employer _____

4 Orthodontic Insurance Information

PRIMARY

Orthodontic Coverage ☐ Yes ☐ No

Insured's Name _____ Relation _____

Insured's Birthdate _____ Insured's SSN _____

Insured's Employer _____

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone _____

Group No. (Plan, Local or Policy #) _____

SECONDARY

Orthodontic Coverage ☐ Yes ☐ No

Insured's Name _____ Relation _____

Insured's Birthdate _____ Insured's SSN _____

Insured's Employer _____

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # _____

Group No. (Plan, Local or Policy #) _____

5 Emergency Contact Information

NEIGHBOR OR RELATIVE NOT LIVING WITH YOU

Name/Relation _____

Phone _____

Email _____

Ashley L. Reynolds D.D.S., M.S.
TEL 248.437.3377 · FAX 248.437.4722
www.crescentorthodontics.com

Dr. Ashley L. Reynolds
CRESCENT ORTHODONTICS PLLC

PATIENT INFORMATION FOR PATIENTS OVER 18 YEARS OF AGE

6 Medical History

Physician _____

Phone _____ Date of Last Visit _____

Your current physical health is ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain _____

Are you taking any prescription / over-the-counter drugs? ☐ Yes ☐ No

Please list each one _____

FEMALE PATIENTS ONLY

Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week # _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

- ☐Y ☐N Abnormal bleeding
- ☐Y ☐N Anemia
- ☐Y ☐N Artificial Bones / Joints / Valves
- ☐Y ☐N Asthma / Arthritis
- ☐Y ☐N Blood Transfusion
- ☐Y ☐N Cancer / Chemotherapy
- ☐Y ☐N Congenital Heart Defect
- ☐Y ☐N Diabetes
- ☐Y ☐N Difficulty Breathing
- ☐Y ☐N Drug / Alcohol Abuse
- ☐Y ☐N Emphysema
- ☐Y ☐N Epilepsy / Seizures / Fainting
- ☐Y ☐N Fever Blisters / Herpes
- ☐Y ☐N Glaucoma
- ☐Y ☐N Heart Attack / Stroke
- ☐Y ☐N Heart Murmur
- ☐Y ☐N Heart Surgery / Pacemaker
- ☐Y ☐N Hemophilia
- ☐Y ☐N Hepatitis
- ☐Y ☐N High / Low Blood Pressure
- ☐Y ☐N HIV+ / AIDS
- ☐Y ☐N Hospitalized for Any Reason
- ☐Y ☐N Kidney Problems
- ☐Y ☐N Mitral Valve Prolapse
- ☐Y ☐N Psychiatric Problems
- ☐Y ☐N Radiation Treatment
- ☐Y ☐N Rheumatic / Scarlet Fever
- ☐Y ☐N Severe / Frequent Headaches
- ☐Y ☐N Shingles
- ☐Y ☐N Sickle Cell Disease / Traits
- ☐Y ☐N Sinus Problems
- ☐Y ☐N Tuberculosis (TB)
- ☐Y ☐N Ulcers / Colitis
- ☐Y ☐N Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

Are you allergic to any of the following?

- ☐Y ☐N Aspirin
- ☐Y ☐N Any Metals / Plastics
- ☐Y ☐N Codeine
- ☐Y ☐N Dental Anesthetics
- ☐Y ☐N Erythromycin
- ☐Y ☐N Latex
- ☐Y ☐N Penicillin
- ☐Y ☐N Tetracycline
- ☐Y ☐N Other

Please list any other drugs/materials that you are allergic to:

_____

7 Dental History

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

_____

_____

Have you ever had or been evaluated for orthodontic treatment? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ/ TMD)? ☐ Yes ☐ No

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had an injury to your: ☐ Mouth ☐ Teeth ☐ Chin

Do you have any speech problems? ☐ Yes ☐ No

Do you generally breathe through your mouth? ☐ Yes ☐ No

If yes, please check ☐ While awake? ☐ While asleep?

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

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Have you ever taken Phen-Fen? ☐ Yes ☐ No

Do you smoke or use tobacco in any form? ☐ Yes ☐ No

8 Release /Agreement

I authorize this office to affix my name to any and all claims or documents related to any and all dental benefits due me and my dependents through my employment. I authorize payment of dental benefits otherwise payable to me, directly to this office.

I understand that where appropriate, credit bureau reports may be obtained.

I certify that I have read and understand the foregoing questions. To the best of my knowledge, the foregoing questions have been completely and accurately answered. In addition, I will notify the doctor of any change in my health history.

Patient Signature: _____

Parent/Legal Guardian Signature: _____

9 Updated Health History Personal Information

Date _____	Date _____	Date _____	Date _____	Date _____
Initials _____	Initials _____	Initials _____	Initials _____	Initials _____