DURHAM ORTHODONTICS

124 Brookridge Drive
Madison, AL 35758
256-325-0078
256-325-0079
info@bracesbydurham.com
www.bracesbydurham.com

Welcome to our practice!

Please complete and submit at your earliest convenience.

1. Patient Information:

First Name: _____ Middle Initials: _____ Last Name: _____

Date of Birth: _____ Birth Sex: ○ Female ○ Male

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Work Phone: _____ Email: _____

Preferred contact method:
○ Mobile Phone ○ Work Phone ○ Email

2. Primary Responsible Party Information: (Example: Mother, Father, Legal Guardian)

First Name: _____ Middle Initials: _____ Last Name: _____

Relationship to Patient
○ Mother ○ Father ○ Self ○ Spouse
○ Stepmother ○ Stepfather ○ Grandmother
○ Grandfather ○ Aunt ○ Uncle ○ Other

Date of Birth: _____

Gender:
○ Female ○ Male ○ Nonbinary

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Work Phone: _____ Email: _____

Social Security Number: _____ Employer: _____ Occupation: _____

Marital Status
○ Single ○ Married ○ Divorced ○ Widowed

Preferred contact method:
○ Mobile Phone ○ Work Phone
○ Email ○ Text

3. Secondary Responsible Party Information: (Example: Mother, Father, Legal Guardian)

First Name: _____ Middle Initials: _____ Last Name: _____

Relationship to Patient
○ Mother ○ Father ○ Self ○ Spouse
○ Stepmother ○ Stepfather ○ Grandmother
○ Grandfather ○ Aunt ○ Uncle ○ Other

Date of Birth: _____

Gender:
○ Female ○ Male

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Work Phone: _____ Email: _____

Social Security Number:

Employer:

Occupation:

Marital Status
○ Single ○ Married ○ Divorced ○ Widowed

Preferred contact method:
○ Mobile Phone ○ Work Phone
○ Email ○ Text

4. Drivers License: Please take a photo of the back and front of your drivers license.

5. How did you learn about our practice or whom may we thank for referring you?

Referral Source
☐ Google ☐ Dentist ☐ Friend/Family ☐ Social Media ☐ Sign or billboard ☐ Insurance Provider List

Friend or family (enter name)

Other Website

Other

6. Has anyone else in the family seen us before? If yes, who is the patient?

7. What is your primary concern(s)?

8. Has your child had previous orthodontic treatment or seen another orthodontist?

○ Yes ○ No

9. General Dentist Information:

Dentist Name:

Dental visit in last 6 months?:
○ Yes ○ No

10. Do you have Orthodontic Insurance?

○ Yes ○ No

11. Primary Dental Insurance

Primary Insurance Company

Employer:

Member ID / Policy #

Group Number

Insured Social Security #

Patient Relationship to Insured
○ Self ○ Spouse ○ Child
○ Other

Insured Name

Insured Phone #

Insured Date of Birth

Insured Street Address

Insured City

Insured State

Zip Code

12. Primary Insurance Card: Please take a photo of the back and front of your insurance card. Should treatment be recommended, providing your insurance card will allow us to share the portion of your orthodontic treatment fee covered by your plan.

13. Do you have Secondary Dental Insurance?

○ Yes ○ No

14. Secondary Dental Insurance

Secondary Insurance Company _____ Employer: _____ Member ID / Policy # _____

Group Number _____ Insured Social Security # _____ Patient Relationship to Insured ○ Self ○ Spouse ○ Child ○ Other

Insured Name _____ Insured Phone # _____ Insured Date of Birth _____ Insured Street Address _____

Insured City _____ Insured State _____ Zip Code _____

15. Secondary Insurance Card: Please take a photo of the back and front of your insurance card. Should treatment be recommended, providing your insurance card will allow us to share the portion of your orthodontic treatment fee covered by your plan.

16. Check if patient has or has had any of the following:

- ☐ Anemia
- ☐ Asthma/COPD
- ☐ Bleeding abnormally
- ☐ Cancer Treatment
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ GERD/Acid Reflux
- ☐ Headaches/Migraines
- ☐ Heart problems
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV AIDS
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ PREGNANT (Currently)
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Tobacco use

Other/Details:

_____

17. Indicate any history of (check all that apply); If checked "Yes", please explain.

- ☐ Thumb/finger sucking
- ☐ Tongue and/or swallowing problems
- ☐ Speech problems
- ☐ Loose teeth or broken fillings
- ☐ Grinding and/or clenching of teeth
- ☐ Tonsils and adenoids removed
- ☐ Crowns/Bridges
- ☐ Root canals
- ☐ Mouth breathing
- ☐ Snoring
- ☐ History of wearing a mouthguard at night
- ☐ History of Periodontal disease
- ☐ History of Periodontal treatment
- ☐ Mouth sores
- ☐ Injury to face or teeth
- ☐ Jaw Pain
- ☐ Clicking or popping jaw
- ☐ Difficulty opening or closing jaw
- ☐ Sensitivity when biting
- ☐ Cold, hot, or sweets sensitivity
- ☐ Food collection between certain teeth

Other/Details:

_____

18. Allergies (Check all that apply)

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Latex
- ☐ Metal/Jewelry
- ☐ Penicillin
- ☐ Plastic
- ☐ None of the Above

Please list any other allergies the patient has:

_____

19. List current medications and the correlating diagnosis:

	Medication	Diagnosis
1		
2		

20. Any serious illnesses or operations? If yes, please describe.

_____

21. If treatment is recommended, how soon would you like to get started?

☐ ASAP ☐ Within the week ☐ Within the month

_____ _____ _____

Other:

_____

22. What payment option(s) would you like to review?

☐ No-Interest Monthly Payment ☐ Payment in Full w/Special Courtesy ☐ HSA/FSA

_____ _____ _____

Other:

_____

23. Is there anything else you would like us to know before your visit?:

_____

To the best of my knowledge, the above questions have been accurately answered. I am aware it is my responsibility to inform this office of any changes to my medical status. I permit to perform necessary orthodontic records, and I am aware you may use these records for in-office education.

_____ _____

Signature Date