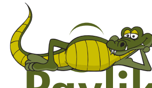
WELCOME!



Pavlik ORTHODONTICS

Welcome to Pavlik Orthodontics! We strive to give patients a great smile along with a great bite. In doing so, we make high quality care and customer service our top priority.

About You

Today's Date: ________________ File #: ___________

Patient Name: ______________________________________

LAST FIRST MI

What do you prefer to be called? ____________________

☐ Male ☐ Female

DOB: ___________ Age: ____ SS#:________________

Mailing Address: ___________________________________

____

CITY STATE ZIP

Home Phone: ( ) ______________________________

Work Phone: ( ) ____________________ Ext: _____

Cell Phone: ( ) ______________________________

Email: ____

Referred by: _______________________________________

Employer: ____________________ How long? __________

Employer's Address: ______________________________

____

CITY STATE ZIP

Occupation: ____

Status: ☐ Minor ☐ Single ☐ Married

☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name: _____________________________________

Do you have children? ☐ Yes ☐ No How many? _____

Account Information

Name: ____

Relation: ____

Billing Address: ___________________________________

____

CITY STATE ZIP

SS#: ____

Drivers License #: _________________________________

Work Phone: ( ) ____________________ Ext: _____

____

INITIALS

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Insurance Information

Primary Dental Insurance

Co. Name: ____

Address: ____

____

CITY STATE ZIP

Phone: ( ) ________________________________

Insured's ID#: _____________________________________

Group (Plan, Local, or Policy) #: ___________________

Insured's Name: ____________________________________

Relation: _______________ DOB: ___________________

Insured's Employer: _________________________________

Secondary Insurance

Co. Name: ____

Address: ____

____

CITY STATE ZIP

Phone: ( ) ________________________________

Insured's ID#: _____________________________________

Group (Plan, Local, or Policy) #: ___________________

Insured's Name: ____________________________________

Relation: _______________ DOB: ___________________

Insured's Employer: _________________________________

In Event of Emergency

Whom should we contact?: ___________________________

Relation: ____

Home Phone: ( ) ____________________________

Work Phone: ( ) ____________________ Ext: _____

Cell Phone: ( ) _____________________________

Who is your Medical Doctor?: _________________________

Doctor's Phone: ( ) ___________________________

Please continue on back

REFERRAL SOURCE

Whom may we thank for referring you? ☐ Dentist ☐ Patient ☐ TV Commercial ☐ Internet Search ☐ Insurance ☐ Radio ☐ Yellow Pages ☐ Sports ☐ Other (specify) ____________________

Name of Referrer:

DENTAL/MEDICAL HISTORY

What is your main reason for visiting the orthodontist today?

General Dentist: Phone:

Address: Last Visit:

Have you ever had any pain or tenderness in the jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

Do your gums bleed? ☐ Yes ☐ No

How many times a week do you floss? How many times a day do you brush?

Physician Name: Phone: Last Visit:

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription drugs? ☐ Yes ☐ No

Drug and Dose:

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

Explain:

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Y **N** Prosthesis	**Y** **N** Tuberculosis	**Y** **N** Convulsions/Epilepsy	**Y** **N** Severe/Freq Headaches
Y **N** Heart Attack	**Y** **N** Shingles	**Y** **N** Abnormal Bleeding	**Y** **N** Hi/Lo Blood Pressure
Y **N** Cancer	**Y** **N** Fever Blister	**Y** **N** Artificial Valves	**Y** **N** Drug/Alcohol Abuse
Y **N** Diabetes	**Y** **N** Scarlet Fever	**Y** **N** Heart Surgery/Pacemaker	**Y** **N** Blood Transfusion
Y **N** Rheumatic Fever	**Y** **N** Ulcers/Colitis	**Y** **N** Any Stays in Hospital	**Y** **N** Anemia/Radiation Therapy
Y **N** HIV+/AIDS	**Y** **N** Heart Murmur	**Y** **N** Kidney/Liver Problems	**Y** **N** Glaucoma
Y **N** Hemophilia	**Y** **N** Emphysema	**Y** **N** Mitral Valve Prolaspe	**Y** **N** Difficulty Breathing?
Y **N** Asthma	**Y** **N** Sinus Problems	**Y** **N** Artificial Bones/Joints	**Y** **N** Other: ____________
Y **N** Hepatitis	**Y** **N** Congenital Heart Defect		

Are you allergic to any of the following?:

Y **N** Aspirin	**Y** **N** Dental Anesthetics	**Y** **N** Tetracycline	**Y** **N** Other: ____________
Y **N** Antibiotics	**Y** **N** Latex	**Y** **N** Penicillin	**Y** **N** **Women Only:** Are you pregnant?

CONSENT TO X-RAYS AND EXAMS

It is necessary to take diagnostic x-rays in order to determine an appropriate treatment plan and patient diagnosis. Your signature below authorizes Pavlik Orthodontics to take these necessary x-rays.

I understand the information that I have given is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my medical status.

Signature of Patient/Legal Guardian Date

S. Jason Pavlik, DMD Date