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: _____

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: ( ) _____

_____
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).

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 Prolapse	☐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