STEVEN W. BLACK · DDS
Specialist in Orthodontics
for Children & Adults

14795 SW. Murray Scholls Drive, Suite 119
Beaverton, Oregon 97007
503.524.0524

Pt #__________________

PATIENT INFORMATION

Date__________________________

Patient's name____ Gender________
FIRST MIDDLE LAST

I prefer to be called_________________________ Birthdate___________________ Home phone_______________________

Address____
STREET CITY ZIP

If patient is a minor, give parents'/guardians' names ____

Other family members treated here____

Whom may we thank for referring you to our office?____

RESPONSIBLE PARTY INFORMATION

Name____Relationship to patient_______________
FIRST MIDDLE LAST

Address____
STREET CITY ZIP

Home phone______________________________________ Work phone ______________________________________

Cell phone____ email____

Social Security Number ____________________________ Employer____

Spouse's name____Relationship to patient_______________
FIRST MIDDLE LAST

Cell phone ____ Work phone_______________________________________

Social Security Number ____________________________ Employer____

EMERGENCY INFORMATION

Name______________________________ Phone______________________ Relationship to patient______________________

ORTHODONTIC INSURANCE

Primary Insurance

Insurance company_________________________________

Insurance company phone___________________________

Insured's name______________________`______________

Insured's address__________________________________

____

Insured's ID#________________Birthdate_____________

Insured's relation to patient__________________________

Insured's employer_________________________________

Secondary Insurance

Insurance company_________________________________

Insurance company phone___________________________

Insured's name______________________`______________

Insured's address__________________________________

____

Insured's ID#________________Birthdate_____________

Insured's relation to patient__________________________

Insured's employer_________________________________

I authorize insurance payment directly to Steven W. Black, DDS the benefits otherwise payable to me, but not to exceed the charges. I understand I'm responsible for payment of charges that insurance doesn't cover.

Signature____Date_________________________

HEALTH HISTORY

Physician________________________ Date of last visit________________________

Address ________________________ Phone________________________

Please circle Yes or No (if Yes, please fill in details)

Yes No Taking any medication?________________________

Yes No History of major illness?________________________

Yes No Surgeries?________________________

Yes No Tobacco use?________________________

Female patients only:

Yes No Has menstruation started?________________________

Yes No Currently pregnant?________________________

Circle any of the medical conditions below that you have had or currently have:

Asthma/Lung Problems	Disabilities	Hepatitis/Liver Problems
Attention Deficit	Drug/Alcohol Abuse	Herpes
Blood Disorder/Transfusion	Epilepsy/Seizures/Fainting	HIV/Aids
Bone Disorder/Osteoporosis	Gastrointestinal Disorders	Psychiatric
Cancer/Chemotherapy	Headaches	STD's
Diabetes	Heart Problems	Tuberculosis

Are there any other medical conditions that we should be aware of?________________________

____

Circle any confirmed allergies you have:

Acetominophen Aspirin Ibuprofen Latex Nickel Lactose intolerance

Other (please explain)________________________

DENTAL HISTORY

General Dentist________________________ Date of last visit________________________

What concerns you most about your smile?________________________

Yes No History of lost or chipped teeth?________________________

Yes No Injury to face, mouth or teeth?________________________

Yes No Do the gums bleed when brushing?________________________

Yes No Is there a thumb habit or tongue thrust?________________________

Yes No Mouth breather?________________________

Yes No Ever seen an orthodontist? Who/When?________________________

Yes No Jaw clicking or popping? When?________________________

Yes No Awareness of teeth clenching during the day?________________________

Yes No History of grinding teeth?________________________

AUTHORIZATION FOR ORTHODONTIC EVALUATION

I understand the information I have given is correct to the best of my knowledge and that it is my responsibility to inform this office of changes in my/my child's medical status. I authorize Steven W. Black, DDS to perform a complete orthodontic evaluation.

Signature:________________________ **Date:**________________________