Jay M. Decoteau D.M.D., P.C.

ADULT PATIENT INFORMATION

Date: _____

PATIENT'S NAME: _____ Birthdate: _____ Age: _____ □ Male □ Female
Last First Middle

Residence: _____
Street City State Zip

Mailing Address: _____
Street City State Zip

Home Phone #: _____Cell Phone #: _____Cell Phone Provider:_____

Social Security #: _____-_____-_____ E-mail Address: _____

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed □ Partnered

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

SPOUSE'S INFORMATION

SPOUSE'S NAME: _____ Birthdate: _____ Age: _____
Last First Middle

Mailing Address:_____
Street City State Zip

Home Phone #: _____ Work Phone #: _____Cell Phone #: _____

Social Security #: _____-_____-_____ E-mail Address: _____

DENTAL INSURANCE INFORMATION

Do you have orthodontic coverage? □ Yes □ No (If no, skip to next section)

PRIMARY ORTHODONTIC INSURANCE ***Insured's Name :*** _____ Birthdate: _____

Insurance Company Name: _____Group #: _____ID #: _____

Insurance Co. Address: _____ Phone #: _____

Do you have dual coverage? Yes_____ No _____

SECONDARY ORTHODONTIC INSURANCE ***Insured's Name:*** _____ Birthdate: _____

Insurance Company Name: _____Group #:_____ ID #:_____

Insurance Co. Address: _____ Phone #: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Phone #: _____ Relation: _____

MEDICAL HISTORY

PHYSICIAN: _____ Date of Last Visit: _____
Address: _____ Phone #: _____

ALLERGIES:

Yes No Are you allergic to any latex, metals, nickel or plastics? *Please list:* _____
Yes No Are you allergic to any medication / things? *Please list:* _____

Have you ever had any of the medical conditions listed below: Yes _____ No _____ *If yes, please circle:*

Abnormal Bleeding	Bone Disorders	Gastrointestinal Disorders	High/Low Blood Pressure	Psychiatric Problems
ADD/ADHD	Cancer/Tumor	Hearing Impairment	HIV/AIDS	Radiation/Chemotherapy
Anemia	Congenital Heart Defect	Heart Problems/Murmur	Kidney Problems	Rheumatic Fever
Arthritis	Diabetes	Hemophilia	Nervous Disorders	Severe/Frequent Headache
Artificial Bones/Joints/Valves	Dizziness	Hepatitis/Liver Problems	Pneumonia	Sinus Problems
Asthma	Epilepsy/Seizures	Herpes/Fever Blisters	Prolonged Bleeding	Tuberculosis

Are you taking any medication? *Please list:* _____
Do you have a history of a major illness? *Please list:* _____
Have you had any operations or been involved in a serious accident? *Please list:* _____
Are there any handicaps/disabilities that we should be aware of? _____
Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

For Women: Are you pregnant? Week # _____

DENTAL HISTORY

GENERAL DENTIST: _____ Date of Last Visit: _____
What concerns you most about your teeth? _____

Have you ever had any of the habits listed below: Yes _____ No _____ *If yes, please circle:*

Clenching Teeth	Nail Biting	Lip Sucking	Mouth Breathing
Grinding Teeth	Tongue Thrust	Lip Biting	Speech Problems

Yes No Have you ever been evaluated for orthodontic treatment? _____
Yes No Are you sensitive or self-conscious about your teeth? _____
Yes No Has anyone in your family received orthodontic treatment? _____
If yes, how did they feel about the result? _____

Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
Yes No Are you presently in any dental pain? _____
Yes No Is any part of your mouth sensitive to temperature or pressure? Where? _____
Yes No Have there been any injuries to your face, mouth, or teeth? _____
Yes No Have you been informed of any missing or extra teeth? _____
Yes No Have you ever lost or chipped any permanent teeth? _____
Yes No Do your gums bleed when brushing? _____
Yes No Have your wisdom teeth been removed? _____

Yes No Do your teeth or jaws ever feel uncomfortable first thing in the morning? _____
Yes No Do you ever experience jaw clicking or popping? _____
Yes No Do you experience “tension” headaches?

I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. I understand that my diagnostic records may be used for educational and promotional purposes. In addition, I authorize Dr. Jay Decoteau and staff to perform the necessary dental services I may need.

Patient Signature: _____ *Date*: _____

I understand that I am responsible for payment of services rendered and also for paying any co-payments and deductibles that my insurance does not cover. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Patient Signature: _____ *Date*: _____

This office reserves the right to verify the credit status of perspective patients seeking treatment prior to extending credit for orthodontic fees and may, at the discretion of the office, use the services of credit reporting services.

Patient Signature: _____ *Date*: _____