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Practice Limited to Orthodontics
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Sioux City LeMars Wayne
Daniel Kaler DDS
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WELCOME

We would like to welcome you to our office. In an effort to Provide the best service, we ask you to fill out this form completely. Thank You for your cooperation.

Members American Association of Orthodontists

ADULT PATIENT INFORMATION

NAME: _____ _____ _____ _____
Last First Middle M/F

ADDRESS: _____ _____ _____ _____
Street City State Zip

BIRTHDATE: _____/_____/_____ AGE: _____

FAMILY DENTIST: _____ DATE OF LAST DENTAL EXAM: _____

HOME PHONE # _____ CELL PHONE # _____

E-Mail Address: _____ This office sends appointment reminders via E-Mails and Text Messages

Who May We Thank for Referring You to Our Office? _____

Please Describe Your Orthodontic Problem _____

SPOUSE'S NAME: _____ _____ _____ _____
Last First Middle M/F

Marital Status: *Married* *Divorced* *Separated* *Widowed* *Single* *Remarried*

	SELF	**SPOUSE**
Employer Name:	_____	_____
Business Address:	_____	_____
Occupation:	_____	_____
Social Security #	_____	_____

Name and Address of Any Other Responsible Party: _____

_____

Orthodontic Insurance – Primary

Policy Holder Name: _____

ID#_____ Birth Date _____

Employer: _____

Please Present your Insurance Card to the Front Desk

Orthodontic Insurance – Secondary

Policy Holder Name: _____

ID#_____ Birth Date _____

Employer: _____

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DENTAL HISTORY

How Often Do You Visit Your Family Dentist? 6 Months 12 Months Only When Needed

Is There Any Unfinished Dental Work to Be Done? NO **YES**_____

Have You Had Any Facial or Dental Injuries? NO YES_____

Have You had any Orthodontic Treatment in the Past? NO YES, What?_____

Do You Have Any History of TMJ Disorder? NO YES _____

Has anyone in your family had Orthodontic Treatment? NO YES, Names: _____

Do You Require Antibiotics Before Dental Procedures? ……..... NO **YES** (Your Family Dentist will write a prescription When Needed)

MEDICAL HISTORY

Physician's Name:_____Address:_____Phone # _____

Are You Taking Any Osteoporosis or "Bone Building" Medications? ..... NO **YES** (Please List Below)
Are You Being Treated by a Physician for any Condition? …… NO YES (Please List Below)
Are You Taking Any Medications? …… NO YES (Please List Below)
Do You have any Allergies to Latex or Medications? …… NO **YES** (Please List Below)

Have You had or have any of the Following?

Heart Murmur…… NO YES

Heart Surgery …… NO YES

Asthma …… NO YES

Hepatitis…….. NO YES

Diabetes……NO YES

Tuberculosis……NO YES

Growth Disorders……NO YES

Emotional Problems……..NO YES

Frequent Headaches……..NO YES

Osteoporosis/Bone Disorders……....NO YES

Mouth Breather……...NO YES

Prosthetic Joint Replacement……NO YES

Please List All Medications:

Please Describe Any Medical Conditions now being treated:

Is There Any Other Information We Should Know?

Patient Signature Reviewed By DATE

A Credit Rating will be obtained from Orthobanc LLC for anyone setting up a payment plan in our office. *04/01/13*