Welcome to Vibeto Orthodontics!

Patient Information

Today's Date: __________

Patient Name: ___________________________________ Nickname: __________________

Address: _______________________________ City: ______________ State: ___ Zip: ___________

Home Phone: ___________________________ Cell Phone: ________ Work Phone: ________________

Birth date: _____________________________ Age: ______________ Sex: ___ SSN#: __________

School: ________________________________ Grade: ____________

Siblings: Name: ______________ Age: ______ Name: ____________ Age: ____

Employer and Occupation: _________________________________

Physician's Name: _____________ Physicians Phone #: ______________

Dentist Name: ________________ Date of Last Visit: ________________ Last X-Rays: _________

Whom may we thank for referring you to our office? Dentist_________ Friend_______ Self_______ Advertisement ________

Responsible Party Information

Primary Responsible Party/Self: ____

Home Phone: __________________ Cell Phone: ______________ Work Phone: __________________

Address: _______________________ City: __________ State: ___ Zip: ______________________

Home Phone: __________________ Work Phone: ____________ Cell Phone: ___________________

Social Security #:________________ Birth Date: ______________ Relationship to Patient: __________

Employer: ______________________ Occupation: _____________ # of Years Employed: ____________

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Secondary Responsible Party or Spouse: ____

Home Phone: __________________ Cell Phone: _____________ Work Phone: _______________

Address: ________________________ City: __________ State: ___ Zip: ______________________

Home Phone: __________________ Work Phone: ____________ Cell Phone: ________________

Social Security #:________________ Birth Date: ______________ Relationship to Patient: _______

Employer: ______________________ Occupation: _______________ # of Years Employed: _________

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Person financially responsible for this account: Father ☐ Mother ☐ Self ☐

Dental Insurance Information

Insured's Name: __________________________ Birth Date: _____________ SS#/ID#: _______________________

Insurance Company: _______________________ Group No: _____________ Phone: ________________________

Insurance Company Address: _______________ City: __________________ State: ___________ Zip: ______

Do you have duel coverage? ☐ Yes ☐ No

2nd Insured's Name: _______________________ Birth Date: _____________ SSN/ID#: _____________________

Insurance Company: _______________________ Group No: _____________ Phone: ______________________

Insurance Company Address: _______________ City: __________________ State: ___________ Zip: ______

Emergency Information

Name of nearest relative not living with you: _________________________

Complete Address: _________________________ City: _____________ State: __________ Zip: ______

Phone: ____________

Medical History

Have you had any of the following?

Aids/HIV	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Periodontal Problems	☐ Yes ☐ No
Autoimmune	☐ Yes ☐ No	Drug Allergies	☐ Yes ☐ No	Fainting, Dizziness	☐ Yes ☐ No
Immune Problems	☐ Yes ☐ No	Organ Transplant	☐ Yes ☐ No	Pregnant	☐ Yes ☐ No
Allergies	☐ Yes ☐ No	Painful Chewing	☐ Yes ☐ No	Due Date: _________________	
Latex	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Artificial Heart Valves	☐ Yes ☐ No
Nickle	☐ Yes ☐ No	Anemia	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No
Other: _______________________		Headaches	☐ Yes ☐ No	Type: ___________________	
Arthritis	☐ Yes ☐ No	Heart Condition	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Prolonged Bleeding	☐ Yes ☐ No	Bone Disorders	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	Cancer	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Cerebral Palsy	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Thyroid	☐ Yes ☐ No
Seizures	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	TMJ Problems	☐ Yes ☐ No
Clicking of the Jaw	☐ Yes ☐ No	Liver Problems	☐ Yes ☐ No	Cold Sore	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Other: ____			

Have you ever taken bisphosphonates? ☐ Yes ☐ No

Please list any medications you are taking: ____

Are you currently being treated by a physician? If so, why? _______________________________________

Dental History

Are you aware of any missing or extra teeth?	☐ Yes ☐ No	Are you presently in dental pain?	☐ Yes ☐ No
Have you ever lost or chipped a tooth?	☐ Yes ☐ No	Do you have any type of thumb or tongue habit?	☐ Yes ☐ No
Do your gums bleed?	☐ Yes ☐ No	Have you ever seen an orthodontist before?	☐ Yes ☐ No
Are you a mouth breather?	☐ Yes ☐ No	If yes, Who and when? ________________	
Does your jaw click or pop?	☐ Yes ☐ No	Has anyone in your family received orthodontic care?	☐ Yes ☐ No
Do you clench or grind your teeth?	☐ Yes ☐ No		

Have you ever had any injuries to your face, mouth or teeth? ☐ Yes ☐ No

Are you aware that some of your appointments will be during school/work? ☐ Yes ☐ No

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered, I understand that providing incorrect information can be dangerous to my (or my child's) health. It is my responsibility to inform the dental office of any changes in my (or my child's) medical status. I authorize the release of any information concerning my (or my child's) healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize insurance payment benefits payable to me directly to the doctor.

X____Date:__________

Signature of patient (Parent or guardian signature if patient is a minor)

Acknowledgement of Receipt of Notice of Privacy Practices

A copy of our privacy practice information is available from our office. Please read through this at your first visit and then sign below.

I, ______________________________ have read a copy of the office's Notice of Privacy Practices.

Please print name: ____

Signature: ____

Date: _______________________________