Welcome to Benham Orthodontics

Adam W. Benham, DDS, MS

PATIENT INFORMATION

PatientName____ Date_____/_____/_______
Address____City___________State_____ZIP_______
Home Phone_____-_____-_____Birth date____/____/____SS#_____-_____-_____Patient Age_______
E-mail Address_____________________________________ (for email appointment confirmations)
How did you hear about our office? ______________________ Patient's Dentist_______________

RESPONSIBLE PARTY INFORMATION

Responsible Party's Name__________________________ Relationship to Patient _____________
Mailing Address________________________________City_____________State_____Zip______
How many years at current address? _____Home Ph._____-_____-_____ Cell Ph._____-_____-______
Previous Address (if less than 3 yrs.)____________________City ___________State ____Zip_____
E-mail Address_____________________________________ (for email appointment confirmations)
SS#______-______-______Birth date______/______/______ Drivers License#______________________
Employer _________________________Work Ph. ________________________ No. of years____
Employer Address____________________________________Occupation__________________

Father/Guardian Name ____________________________________Check if same as above ( )
Mailing Address________________________________City___________State______Zip_______
Home Ph._____-____-_____ Work Ph. _____-____-_____ SS#______-___-_____Birth date____/____/____
Employer____No. of years____________
Employer Address____________________________________Occupation__________________

Mother/Guardian Name ___________________________________Check if same as above ( )
Mailing Address________________________________City___________State______Zip_______
Home Ph.____-_____-_____ Work Ph. ____-_____-_____ SS#______-____-_____Birth date____/____/____
Employer____No. of years____________
Employer Address____________________________________Occupation__________________

DENTAL INSURANCE INFORMATION

Insured's Name ________________________Birth date___/____/____ Insured's SS#_____-____-_____
Insurance Company___________________________Policy#________________Group#________
Insurance Company Address____
Insurance Company Phone#______-______-_____ Insured's Employer________________________
Secondary Insured's Name______________________________ Insured's SS#_____-______-_______
Secondary Insurance Company Address ____
Secondary Insurance Company Phone #____-_____-______ Secondary Insured's Employer__________

EMERGENCY INFORMATION

Emergency Contact (other than guardian) ____

Relationship____________________ Daytime Ph.____-______-_____Alternative Ph.____-_____-_____

I certify that all of the above information is true and it is my responsibility to inform this office of any changes, and that in order to receive complete information on financial options it is necessary for me to authorize a credit report.
Signature (Guardian's Signature if a minor) ______________________________Date____/____/____

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HEALTH HISTORY

Initial Date_____/_____/_____ Update 1 _____/_____/_____ Update 2_____/_____/_____

Medical History

Please check Yes or No if the patient has or has ever had:

Y N

[ ] [ ] Joint swelling or Arthritis
[ ] [ ] Bone Disorders
[ ] [ ] Heart Problems
[ ] [ ] Diabetes
[ ] [ ] Thyroid Problems
[ ] [ ] Kidney Problems
[ ] [ ] Rheumatic Fever
[ ] [ ] Hepatitis or Liver Problems
[ ] [ ] Emotional Problems
[ ] [ ] Tuberculosis
[ ] [ ] AIDS / HIV
[ ] [ ] Anemia
[ ] [ ] Asthma
[ ] [ ] Epilepsy
[ ] [ ] Prolonged Bleeding
[ ] [ ] Endocrine Problems
[ ] [ ] Tonsils Removed
[ ] [ ] Adenoids Removed

Dental History

Please check Yes or No if the patient has or has ever had:

Y N

[ ] [ ] Any injury to face, mouth teeth?
[ ] [ ] Thumb, finger or lip sucking Habits(s)?
[ ] [ ] Any speech problems?
[ ] [ ] Mouth breathing when asleep, awake?
[ ] [ ] Any known missing permanent teeth?
[ ] [ ] Any known extra permanent teeth?
[ ] [ ] Any teeth removed by extraction?
When ? __________________________
[ ] [ ] Tongue Thrust?
[ ] [ ] Any wind instruments played?
[ ] [ ] Clenching or Grinding of teeth?
[ ] [ ] Chronically sore or bleeding gums?
[ ] [ ] Jaw Pain, popping, grinding, locking?
[ ] [ ] Difficulty chewing or swallowing food?
[ ] [ ] Frequent Headaches? If Yes, how frequent?
[ ] [ ] Muscle tenderness or stiffness in neck/jaw?
[ ] [ ] Ringing of ear, dizziness?
[ ] [ ] Previous treatment for TMJ or joint problems?

Please list dates and specifics for all "Yes"Answers: ____
____
List any allergies:____
Does patient visit his/her dentist regularly?_________ Has an Orthodontist been consulted previously?_________
List medications presently being taken:____
Reason:____
Has patient experienced a sudden increase in height?_____ Is the patient currently under a physicians care?_____
Does any member of the family or close relative(s) have similar arrangement of the teeth or similar appearance of the jaws? Explain ____
Please list any other dental information known, and not listed above:_____________________________________
____
List any other serious illness not listed above:____
Physician's Name___________________________

The above information is true to the best of my knowledge, and I understand that it is my obligation to update this information as changes become known to me.

Patient/Parent/Guardian Signature ____Date____/_____/_____