Diamond Braces
Align With Us

Patient Information

Date_____

Patient's Name _____/_____ Male☐Female☐
Last First Middle Nickname

Address:_____
Street City State Zip

Date of Birth_____ Age_____ Social Security No._____ Siblings _____ How Many _____ Ages _____

Home Phone_____ Cell Phone_____

E Mail Address _____

If patient is a minor, give parent's or guardian's name and phone # responsible for making appointments_____

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

Responsible Party Information if patient is a minor

Name_____Mr.☐Mrs.☐Ms.☐Dr.☐
Last First Middle

Address_____ Home phone _____
Street City State Zip

Social Security No._____ E-mail_____ Relationship to Patient_____

Employer_____ Occupation_____ No. years employed_____

Spouse's Name_____Relationship to Patient_____

Social Security No._____ E-mail_____ Cell Phone _____

Employer_____ Occupation_____ No. years employed_____

Dental Insurance Information

Insured's Name_____ Insured's Soc Sec No._____ Date of Birth_____

Insurance Co._____ Group No._____ Phone_____

Insurance Co.

Address_____

Do you have dual coverage? Yes ☐No☐ If yes, please complete:

Insured's Name_____ Insured's Soc Sec No._____ Date of Birth_____

Insurance Co._____ Group No._____ Phone _____

Address_____

Emergency Contact Information

Name of nearest relative not living with you_____ Relationship_____

Complete address_____
Street City State Zip

Home phone_____ Other phone_____

I understand that, where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor)_____Updates (date and initial)_____

Dental History

Dentist _____ Phone_____

Last Visit Date _____

What concerns you most about you teeth?_____

Yes☐No☐Are you presently in any dental pain? _____

Yes☐No☐Have you ever experienced any unfavorable reaction to dentistry?

What type of braces are you interested in? ☐Invisalign ☐Regular Metal Braces ☐Clear Braces ☐Lingual Braces

Medical History

Physician_____ Phone_____ Date of Last Visit_____

Please check Yes or No. (If Yes, please fill in details)

Yes☐No☐Are you taking any medications?_____

Yes☐No☐Are you allergic to any medications?_____

Yes☐No☐Do you have a history of a major illness?_____

Yes☐No☐Have you had any major operations?_____

Yes☐No☐Have you ever been involved in a serious accident?_____

For Female Patients Only:

Yes☐No☐Are you pregnant? _____

Benefits. The benefits of orthodontics are aesthetics, health and function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I have truthfully answered all of the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Diamond Braces to perform a complete orthodontic evaluation.

Privacy Policies. I understand that this office is HIPAA compliant. I hereby acknowledge that the privacy statement is available for me to read and obtain a copy at my request.

Signature _____ Date _____