

Welcome! Our specialty is creating smiles and to do this, we treat people, not just teeth. We care about your total health and appreciate your time in completing this health history.



Date \_\_\_\_\_ Updated \_\_\_\_\_

**Patient Information**

Patient Legal Name \_\_\_\_\_ Name you would like to be called \_\_\_\_\_ Male / Female \_\_\_\_\_  
 Address \_\_\_\_\_ Apt.# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Patient E-Mail \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Dentist \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Reason for seeking treatment? \_\_\_\_\_

Mark all the ways you have heard about our office:  Dentist Referral  Dental Office Staff  Location  Reputation  
 Fry Commercial  Fry Website  Invisalign Commercial  Invisalign Website  Insurance Listing  I am a former patient  
 Newspaper/Magazine  Phone Book  Coupon in Mail  Transferring Orthodontist \_\_\_\_\_  
 I know a Fry Orthodontic patient \_\_\_\_\_  
 NAME \_\_\_\_\_  
 Fry Staff Member \_\_\_\_\_ NAME \_\_\_\_\_  Family member had treatment here \_\_\_\_\_ NAME \_\_\_\_\_

**\* REQUIRED \* Responsible Party Information**

Name \_\_\_\_\_ E-Mail \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Marital Status \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Employer \_\_\_\_\_ Occupation \_\_\_\_\_

**Orthodontic Insurance Information**

Primary \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Employer \_\_\_\_\_ Member ID# \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Phone # \_\_\_\_\_  
 Insurance Company Address \_\_\_\_\_ Group # \_\_\_\_\_  
 Secondary \_\_\_\_\_  
 Insured \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Employer \_\_\_\_\_ Member ID# \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Phone # \_\_\_\_\_  
 Insurance Company Address \_\_\_\_\_ Group # \_\_\_\_\_

**Authorization Information**

▶ I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

▶ I hereby authorize payment directly to Robert W. Fry, D.D.S., M.S. of the insurance benefits otherwise payable to me.

\_\_\_\_\_  
 Signed (Patient, or Parent of Minor) Date

\_\_\_\_\_  
 Signed (Insured Person) Date

## Emergency Information

In case of emergency, please contact \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to patient \_\_\_\_\_

## Medical History

Is the patient in good health? Yes / No      Is the patient under the care of a physician? Yes / No      Physician's Name \_\_\_\_\_

If so, explain \_\_\_\_\_

Presently taking any medication? \_\_\_\_\_

If so, explain \_\_\_\_\_

Does the patient have any history of: (please check yes or no) \_\_\_\_\_

Y N	Y N	Y N	Y N	Y N
<input type="checkbox"/> <input type="checkbox"/> Frequent Colds	<input type="checkbox"/> <input type="checkbox"/> Allergies	<input type="checkbox"/> <input type="checkbox"/> Dizziness or Fainting	<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Aids
<input type="checkbox"/> <input type="checkbox"/> Heart Trouble	<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Kidney or liver disease	<input type="checkbox"/> <input type="checkbox"/> T.B.	<input type="checkbox"/> <input type="checkbox"/> Blood Disorders
<input type="checkbox"/> <input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> <input type="checkbox"/> Hepatitis	<input type="checkbox"/> <input type="checkbox"/> Brain injury	<input type="checkbox"/> <input type="checkbox"/> Epilepsy	<input type="checkbox"/> <input type="checkbox"/> Trouble Hearing
<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> Latex Allergy	<input type="checkbox"/> <input type="checkbox"/> Metal Allergy	<input type="checkbox"/> <input type="checkbox"/> or any other medical condition we should be aware of	
<input type="checkbox"/> <input type="checkbox"/> Osteoporosis	<input type="checkbox"/> <input type="checkbox"/> any adverse reactions to anesthesia			

## Dental History

Dentist \_\_\_\_\_ Date of last visit \_\_\_\_\_

Y N

Does patient have any oral habits? (Thumb sucking / lip biting / mouth breathing) \_\_\_\_\_

Does patient have pain in the jaw joints?      Right \_\_\_\_\_ Left \_\_\_\_\_

Does patient have popping or cracking of the jaw joints?      Right \_\_\_\_\_ Left \_\_\_\_\_

When did this begin? \_\_\_\_\_

Does the patient have headaches of any kind? Sinus \_\_\_\_\_ Forehead \_\_\_\_\_ Temple \_\_\_\_\_

How often? \_\_\_\_\_ Ear pain \_\_\_\_\_ Neck / Shoulder pain \_\_\_\_\_

Has any other family member had orthodontic treatment? \_\_\_\_\_

Is there anything else that you feel we should know regarding this patient? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Benefits of Orthodontics

Your protected health information (PHI) may be used in connection with your treatment, payment of your account or health care operations. Our office will not disclose PHI except as otherwise required for treatment, diagnosis, and billing, the individual's rights, and the practice's obligations.

Orthodontics is a service that provides an improvement in the appearance of the teeth and function of the teeth, and in general dental health. Teeth, gums and jaws are intricate body parts 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 state that I have read and understand the above, and have truthfully to the best of my ability answered all of the questions on this form.

Patient / Parent \_\_\_\_\_ Date \_\_\_\_\_

*Thank you so much for taking your valuable time to fill out this form.  
The better we know you, the more we can be of service to you.*