Today's Date:____________

MARK L.UNDERWOOD, D.D.S, M. ED.
Orthodontics and Dentofacial Orthopedics

The benefits of a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset.
Our goal is to make everyone's visit pleasant and educational. Please fill out the information below.

Name:______________________________ SS #:____________
LAST FIRST MIMR MRS MS DR

I prefer to be called:____________ Male Female Birthdate:___/___/___ Age:______

Home Address:______________________________
APT / CONDO # CITY STATE ZIP

Hm #:__________ Wk #:__________ Ext:_____ DL #________ Pager / Cell / Other #:__________

Single Married Divorced Widowed Separated

Employer:______________________ How long there?__________

Employer's Address:______________________________

Occupation:______________ Where & when are best times to reach you?__________

Whom may we thank for referring you?______________________________

Other family members seen by us:______________________________

General Dentist:______________________ Last Visit Date:__________

Spouse's Name:______________ SS #:__________ Birthdate:___/___/___

Employer:______________________ Wk #:__________ Ext:______

Person Responsible for Account:______________ SS #:__________

Billing Address:______________________________

Relation:__________ Wk #:__________ Ext:______ Hm #:__________

Employer:______________________________

OTHODONTIC INSURANCE - Primary

Orthodontic Coverage: Yes No Insurance Co. Name:______________________

Insurance Co. Address:______________________________

Insured Co. Phone Number:______________ Group # (Plan, Local or Policy #):__________

Insured's Name:______________________ Relation:__________

Insured's Birthday:___/___/___ Insured' SS #:______________

Insured's Employer:______________________________

OTHTHODONTIC INSURANCE - Secondary

Orthodontic Coverage: Yes No Insurance Co. Name:______________________

Insurance Co. Address:______________________________

Insured Co. Phone Number:______________ Group # (Plan, Local or Policy #):__________

Insured's Name:______________________ Relation:__________

Insured's Birthday:___/___/___ Insured' SS #:______________

Insured's Employer:______________________________

Emergency Contact Name:______________________________

Relation:______________ Wk #:__________ Ext:______ Hm #:__________

MEDICAL HISTORY:

Do you have a personal physician? Yes No Date of Last Visit:____________________

Physician Name:____ Phone #:____________________

Your current physical health is: Good Fair Poor Are you currently under the care of a physician? Yes No

Please explain:____

Are you taking any prescription / over-the-counter drugs? Yes No

Please list each one:____

Have you ever had any of the following diseases or medical problems?

Y N	Anemia	Y N	Epilepsy / Seizures / Fainting Spells	Y N	HIV+ /AIDS
Y N	Asthma	Y N	Heart Attack / Stroke	Y N	Kidney Problems
Y N	Cancer/Chermotherapy	Y N	Heart Murmur	Y N	Mitral Valve Prolapse
Y N	Congenital Heart Defect	Y N	Heart Surgery / Pacemaker	Y N	Scarlet Fever
Y N	Diabetes	Y N	Hemophilia / Abnormal Bleeding	Y N	Severe / Frequent Headaches
Y N	Difficulty Breathing	Y N	Hepatitis	Y N	Sinus Problems
Y N	Emphysema	Y N	High / Low Blood Pressure		

Please list any serious medical condition(s) that you have ever had:________________________

Please list any allergies you have:____

What are the main concerns that you would like orthodontics to address?________________________

Have you ever been evaluated for orthodontic treatment? Yes No

Have you had any prior orthodontic treatment? Yes No

Have you ever had a serious / difficult problem associated with any previous dental work? Yes No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? Yes No

Your current dental health is: Good Fair Poor

Do you like your smile? Yes No Do your gums ever bleed? Yes No

Have you ever had an injury to your: Mouth Teeth Chin (Please Circle)

Do you have any missing or extra permanent teeth? Yes No

Do you have any tooth sensitivity to hot, cold, or biting pressure? Yes No

Has there been any breakage of fillings, crowns, or enamel? Yes No

Do you have any speech problems?____

Do you generally breathe through your mouth: Yes No *Awake?* Yes No *Asleep?* (Please Circle)

- I understand that the information I have given today is correct to the best of my knowledge. I also understand this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

____

Signature Date

DO NOT WRITE BELOW

Molar Classification Right______________ Left______________

Cuspid Classification Right______________ Left______________

Crowding or spacing evident____

Overjet______________ Overbite______________

Midlines____

Crossbites____

TMJ____

Oral Hygiene____

Gingival conditions______________________ Frenums______________________

Tongue Mobility______________________ Function______________________

Other____

____

READY FOR RECORDS? Yes_____ No_____ RECALL_________ Mos. Panorex only__________