Welcome to Monroe Orthodontics!
We look forward to providing you with the highest level of care and service during your orthodontic journey. Please complete this form prior to your first appointment – the New Patient Exam.
Thank you!

NEW PATIENT FORM — Adult

Today's Date ____________

Whom may we thank for referring you? ____________

Are there other family members we have seen? (names) ____________

General Information About You

Your Name (first /mi /last) ____________ (circle) Mrs. Mr. Ms. Dr.

(circle) Female / Male Marital Status (circle) Married Divorced Separated Single Widowed Partnered

I prefer to be called ____________ Date of Birth (mm/dd/yy) ____________ Age ______

Social Security Number ______-______-______ Home Phone ( ) ____________

Work Phone ( ) ____________ Cell Phone ( ) ____________

Best times to reach you: ____________

Home Address (street/apt #/city/state/zip) ____________

Employer ____________ Occupation ____________

Spouse/ Partner's Name ____________ Home Phone ( ) ____________

Work Phone ( ) ____________ Cell Phone ( ) ____________

What are the main concerns about your smile and teeth that you would like orthodontics to address?

____

____

EMERGENCY CONTACT

Nearest relative not living with patient ____________ Relationship ____________

Address ____________

Home Phone ( ) ____________ Cell / Other Phone ( ) ____________

Responsible Party

If not the patient named above, who is responsible for the account? ____________

Name (first /mi /last) ____________ Date of Birth (mm/dd/yy) ____________

Home Address (street/apt #/city/state/zip) ____________

Billing Address (if different from home) ____________

Social Security Number ______-______-______ Home Phone ( ) ____________

Work Phone ( ) ____________ Cell Phone ( ) ____________

Employer ____________ Occupation ____________

MONROE ORTHODONTICS
CHILDREN AND ADULTS

Insurance Information

If you have Orthodontic Insurance benefits, please complete this section:

PRIMARY

Insurance Company Name ______________________ Insurance Phone (   ) ______________

Insurance Address (street/suite/city/state/zip) ______________________________________

Group # (Plan, Local or Policy #) ____________________ Identification # ____________________

Insured's Name (first /mi /last) ______________________ Date of Birth (mm/dd/yy) ____________

Relation to you ____________________ Insured's employer ______________________________

SECONDARY

Insurance Company Name ______________________ Insurance Phone (   ) ______________

Insurance Address (street/suite/city/state/zip) ______________________________________

Group # (Plan, Local or Policy #) ____________________ Identification # ____________________

Insured's Name (first /mi /last) ______________________ Date of Birth (mm/dd/yy) ____________

Relation to you ____________________ Insured's employer ______________________________

Dental & Medical History

Your General Dentist (Name/ City) ____

Dentist's Phone (   ) ________________ Date of Last Visit ________________

Are you currently under the care of a physician? (circle) Yes / No

If 'yes', please explain: ____

Your Physician (Name/ City) ____

Physician's Phone (   ) ________________ Date of Last Visit ________________

Have you ever been evaluated or had orthodontic treatment before? (circle) Yes No

Have you had any injuries to the face, mouth, teeth or chin? Yes No

Do you require antibiotics before dental treatment? Yes No

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

Have you ever had any pain/tenderness in your jaw joint (TMJ/TMD)? Yes No

Your current physical health is? (circle) Good Fair Poor

Please list all prescription and over-the-counter medications that you are currently taking :________________

____

____

FOR WOMEN: Are you using a prescribed method of birth control? Yes No

Are you pregnant? Yes No

Are you nursing? Yes No

MONROE ORTHODONTICS
CHILDREN AND ADULTS

NEW PATIENT FORM — Adult

Dental & Medical History — cont.

Please list and discuss any serious medical problems you have now or have had: ______________________________

____

____

Please circle Yes or No to the following conditions that you have now or have had:

Condition			Condition			Condition		
Abnormal Bleeding	Y	N	Epilepsy / Seizures	Y	N	Mitral Valve Prolapse	Y	N
Anemia	Y	N	Fever Blisters / Herpes	Y	N	Pacemaker	Y	N
AIDS / HIV +	Y	N	Glaucoma	Y	N	Prosthetics	Y	N
Artificial Bones /Joints /Valves	Y	N	Heart Attack / Stroke	Y	N	Psychiatric Treatment	Y	N
Asthma	Y	N	Hearing Impairment	Y	N	Rheumatic Fever	Y	N
Arthritis	Y	N	Heart Murmur	Y	N	Radiation Treatment	Y	N
Blood Transfusion	Y	N	Hemophilia	Y	N	Scarlet Fever	Y	N
Cancer/ Chemo	Y	N	Hepatitis	Y	N	Sickle Cell Disease /Traits	Y	N
Congenital Heart Defect	Y	N	Heart Surgery	Y	N	Severe Headaches	Y	N
Diabetes	Y	N	High / Low Blood Pressure	Y	N	Sinus Problems	Y	N
Difficulty Breathing	Y	N	Hospital Stay or Operation	Y	N	Tuberculosis (TB)	Y	N
Drug/ Alcohol Abuse	Y	N	Kidney Problems	Y	N	Ulcers / Colitis	Y	N
Emphysema	Y	N	Liver Problems	Y	N	Venereal Disease	Y	N

Indicate by circling Yes or No if you are allergic to the following:

Allergy			Allergy			Allergy		
Aspirin	Y	N	Dental Anesthetics	Y	N	Penicillin	Y	N
Any Metals / Plastics	Y	N	Erythromycin	Y	N	Tetracycline	Y	N
Codeine	Y	N	Latex	Y	N	Other	Y	N

Please list any drugs or additional things that you are allergic to: ______________________________

____

AUTHORIZATION

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. If this office accepts my insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize Monroe Orthodontics to release all information necessary to secure the payment of benefits. And I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Responsible Party ______________________________ Date ____________________

Monroe Orthodontics is HIPPA compliant and is committed to meeting or exceeding the standards of infection control mandated by the OSHA, the CDC, and the ADA.