Welcome to Sonneborn Orthodontics!

sonneborn
arthur a. sonneborn d.d.s.,ms

We would like to welcome you to our office. Our goal is to make every visit pleasant and educational. Please fill out this form completely. The better we communicate, the better we can care for you.

Tell Us About You

Today's Date:_____

Male ☐ Female ☐

Name:_____
LAST FIRST MI

I prefer to be called:_____

Birthdate:____/____/____ Age:_____

HM#:( )_____WK#:( )_____Ext:_____

Cell/Other#:( )_____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Address:_____
APT/ CONDO#

_____
CITY STATE ZIP

Employer:_____

Employer's Address: _____

How did you hear about Dr. Sonneborn? Friends ☐

Radio☐ Dentist ☐ Phonebook ☐ Billboard ☐ Ins Carrier ☐ TV ☐

Other_____ **Check all that apply above**

Other family members seen by us:_____

General Dentist:_____

Last visit date:_____

Spouse Information:

His/Her Name: _____

Birthdate:____/___/___ SS#: _____

Wk#:( )_____Ext:_____

Employer:_____

Employer Address:_____

Tell us the main reason for your visit with us today

_____

_____

_____

*What would you like to accomplish from your visit with us today :*_____

_____

_____

In the event of an emergency, is there someone who lives near you that we should contact?

His/Her Name:_____Relation:_____

WK#:( )_____HM#:( )_____

Person Responsible For Account

Name:_____Relation:_____

Billing Address:_____

_____
City State Zip

Hm#:( )_____Wk#:( )_____Ext:_____

Email address:_____

Employer:_____
CITY STATE ZIP

Orthodontic Insurance Coverage?

Yes ☐ *No* ☐

Primary Insurance:

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone#:( )_____

Group #(Plan, Local, or Policy#):_____

Policy Owner's Name: _____

Relationship to Patient:_____

Policy Owner's Birthdate:___/___/___SS#:_____

Policy Owner's ID #:_____

Secondary Insurance:

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone#:( )_____

Group #(Plan, Local, or Policy#):_____

Policy Owner's Name:_____

Relationship to Patient:_____

Policy Owner's Birthdate:___/___/___SS#:_____

Policy Owner's ID #:_____

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Phone#:( )_____Date of last visit:_____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician?_____

If so, please explain:_____

Are you taking any prescription/ over-the-counter drugs?

☐ Yes ☐ No Please List:_____

For Women:

Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week:_____

Are you nursing? ☐ Yes ☐ No

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

Y N	Anemia/ Radiation Treatment	Y N	Heart Surgery/ Pacemaker
Y N	Artificial Bones/ Joints	Y N	Hemophilia/Abnormal Bleeding
Y N	Artificial Valves	Y N	Hepatitis
Y N	Asthma/ Arthritis	Y N	High/ Low Blood Pressure
Y N	Blood Transfusion	Y N	HIV+/ AIDS
Y N	Cancer/ Chemotherapy	Y N	Hospitalized for Any Reason
Y N	Congenital Heart Defect	Y N	Kidney Problems
Y N	Diabetes/ Tuberculosis (TB)	Y N	Mitral Valve Problems
Y N	Difficulty Breathing	Y N	Psychiatric Problems
Y N	Drug/ Alcohol Abuse	Y N	Rheumatic/ Scarlett Fever
Y N	Emphysema/ Glaucoma	Y N	Severe/ Frequent Headaches
Y N	Epilepsy/Seizures/Fainting Spells	Y N	Shingles
Y N	Fever Blisters/ Herpes	Y N	Sinus Problems
Y N	Heart Attack/ Stroke	Y N	Ulcers/ Colitis
Y N	Heart Murmur	Y N	Venereal Disease

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

Medical History Continued

Are you allergic to any of the following?

Y N	Aspirin	Y N	Dental Anesthetics	Y N	Penicillin
Y N	Any Metal/Plastic	Y N	Erythromycin	Y N	Tetracycline
Y N	Codeine	Y N	Latex	Y N	Other

Please list any other drugs that you are allergic to:_____

_____

Dental History

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

_____

_____

_____

Have you ever had or been evaluated for orthodontic treatment?

☐ Yes ☐ No

Have you ever had a serious/ difficult problem associated with anyprevious 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 speech problems?_____

_____

Do you generally breathe through your mouth?

Y N Awake? Y N Asleep?

(Please Circle One)

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

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

I authorize the orthodontic staff to perform the necessary orthodontic services I may need.

_____

Signature Date

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.

_____

Signature Date

The Individual who signs the Contract is Solely responsible for payment. Thank You

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC & the ADA.