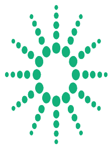

Brilliant | Rothenberg | Meister

PRACTICE LIMITED TO ORTHODONTICS

18851 NE 29th Avenue, Suite 300 | Aventura, FL 33180

305. 933. 1415 P | 305. 933. 1920 F

www.brilliantortho.com

## PATIENT INFORMATION

| Last Name | First Name | Nickname | SS # | Sex | Date of Birth | Age |
|---|---|---|---|---|---|---|
| Mailing Address | | City | | State | Zip | Home Phone |
| School Currently Attending | Grade | [] Single [] Married<br>[] Sep [] Divorced<br>[] Widow(er) | | Email | | Cell Phone |
| Employer | | Employment Address | | | Business Phone | Other Phone |
| Referred by | | Name of Dentist | | | Date of Last Visit to Dentist | |

| Do you know a current or previous patient? | Names & Ages of Other Children |
|---|---|
| | |
| | |

## PARENT/PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT (complete if patient is a minor)

| Father's Name | Mother's Name |
|---|---|
| Address (if different from patient's) | Address (if different from patient's) |
| | |
| City State Zip | City State Zip |
| Home Phone Work Phone | Home Phone Work Phone |
| Cell Phone Fax | Cell Phone Fax |
| SS # Email | SS # Email |
| Employer | Employer |
| Address | Address |
| City State Zip | City State Zip |
| If Divorce is Involved, Who is the Custodial Parent? | May Patient Information Be Released to the Non-Custodial Parent?<br>[ ] Yes [ ] No |

## EMERGENCY CONTACT INFORMATION

| Name of nearest relative, not living with you | | | | | Relationship to Patient | |
|---|---|---|---|---|---|---|
| Mailing Address | | City | | State | Zip | Email |
| Cell Phone | Home Phone | | Work Phone | | Other phone | |

## DENTAL INSURANCE INFORMATION

| Insured's Name | | Date of Birth | Insured's Social Security # |
|---|---|---|---|
| Insurance Company | | Group# | Plan/Type |
| Insurance Phone # | Insured's Signature to assign benefits to Drs. Brilliant, Rothenberg & Meister | | |

# *Medical History*

Physician_______________________________________________________ Date of Last Visit________________________________

Address_________________________________________________________ Phone__________________________________________

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

Yes No Are you taking any medication? ____________________________________________________________

Yes No Are you allergic to any medication? ______________________________________________________

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?__________________________________________

Circle any of the medical conditions below that you have had or currently have.

| | | | |
|---|---|---|---|
| Abnormal bleeding/Hemophilia | Diabetes | Hepatitis/Liver problems | Pneumonia |
| Anemia | Dizziness | Herpes | Prolonged Bleeding |
| Arthritis | Epilepsy | High Blood Pressure | Radiation/Chemotherapy |
| Asthma or Hayfever | Gastrointestinal Disorders | HIV / Aids | Rheumatic Fever |
| Bone Disorders | Heart Problems | Kidney problems | Tuberculosis |
| Congenital Heart Defect | Heart Murmur | Nervous Disorders | Tumor or Cancer |

Are there any medical conditions we have not discussed that you feel we should be aware of? ___________________________________

______________________________________________________________________________________________________

# *Dental History*

Dentist_________________________________________________________ Date of last visit_________________________________

What concerns you most about your teeth? ________________________________________________________________________

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

Yes No Have you ever lost or chipped any teeth? _______________________________________________________________

Yes No Have there been any injuries to face, mouth or teeth? _____________________________________________________

Yes No Is any part of your mouth sensitive to temperature or pressure? ____________________________________________

Yes No Do your gums bleed when you brush? _________________________________________________________________

Yes No Do you have any type of thumb or tongue habit? ________________________________________________________

Yes No Are you a mouth breather? _________________________________________________________________________

Yes No Have you ever seen an orthodontist? If yes, who and when?_______________________________________________

Yes No Would you object to wearing orthodontic appliances (braces) should they be indicated?__________________________

Yes No Has anyone in your family received orthodontic treatment here? If yes, who was it?_____________________________

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning?________________________________

Yes No Are you aware of your jaw clicking or popping?__________________________________________________________

Yes No Are you aware of clenching your teeth during the day?____________________________________________________

Yes No Have you ever been told that you grind your teeth?_______________________________________________________

Yes No Do you have "tension" headaches?___________________________________________________________________

Yes No Have you ever experienced chronic ringing in your ears?___________________________________________________

Yes No If the patient is under age 16, height of parents? Mom_________ Dad_________

**Yes No Are you aware that some appointments will be during school/work hours?_________________________________**

**Female Patients Only:**

Yes No Are you pregnant?_________________________________________________________________________________

Yes No Has menstruation started?__________________________________________________________________________

**Benefits of Orthodontics:** 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 the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Drs. Brilliant, Rothenberg & Meister to perform a complete orthodontic evaluation.

We are sorry that we cannot accept divorce decrees as assignments of responsibility for a child's orthodontic bills. The parent accompanying the child should pay for the services and seek any reimbursement from the other parent. By signing below I am also allowing Drs. Brilliant, Rothenberg & Meister to file claims for any insurance benefits that apply to the treatment I will receive.

Signature ________________________________________________________________ Date ______________________________

Print Name _______________________________________________________________Relationship to Patient ______________________________