DR. BENJAMIN WRIGHT

Board Certified Orthodontist

Medical and Dental Questionnaire

Patient's Name: _____ Nickname: _____ Sex: M / F

Address: _____

City: _____ State: _____ Zip: _____

Home/Cell Phone: _____ Date of Birth: _____ Age: _____

SS#: _____/_____/_____ (this is required for insurance purposes and office payment plans) Marital Status: _____

Employer: _____ Position: _____ Work Phone: _____

EMAIL Address: _____

Family Dentist: _____ Family Physician: _____

Primary Orthodontic Concern: _____

Whom May We Thank for referring you to Our Practice: _____

Spouse Information if Applicable

Spouse's Name: _____

Address: _____ Home/Cell Phone: _____

Date of Birth: _____ SS#: _____/_____/_____(this is required for insurance purposes and office payment plans)

Employer: _____ Position: _____ Work Phone: _____

In case of EMERGENCY, Whom should we contact? _____ Phone # _____

Health Questionnaire

Are you currently under doctor's care? Y / N Condition: _____

Current Medication reason for taking: _____

Allergies: _____

Please circle all conditions that apply to you:

AIDS	No	Yes	Hepatitis	No	Yes	Injury to:		
Arthritis	No	Yes	Herpes	No	Yes	Face	No	Yes
Diabetes	No	Yes	Kidney Disease	No	Yes	Head	No	Yes
Earaches	No	Yes	Rheumatic Fever	No	Yes	Teeth	No	Yes
Heart Problems	No	Yes	Sore Throats	No	Yes			
Hemophilia	No	Yes	Pregnancy	No	Yes			
Adenoids or Tonsils Removed?	No	Yes	Bleeding	No	Yes			

Do you have any children? No Yes ***If yes:***

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Dental Questionnaire

ORAL HABITS

Clenching & Grinding of Teeth:	No	Yes
Difficulties Chewing:	No	Yes
Speech Problems	No	Yes
Gagging	No	Yes

Have you had previous orthodontic treatment? No Yes When?_____

Have we treated other family members in our office? No Yes Names: _____

Jaw Joint Problems:

Clicking & Popping	No	Yes
Pain	No	Yes
Facial Pain	No	Yes

Do your gums bleed: No Yes

How many times per day do you brush: _____

Do you floss: No Yes

Date of last dental visit: _____

Are there any other problems, questions, or concerns not addressed on this form that you think we should be aware of?

_____

_____

Signature:_____ Date:_____

Orthodontist Signature:_____ Date:_____

Dental Insurance Information Form

This form is for DENTAL coverage only. The information you provide will be used to verify your orthodontic benefit, so please fill out this form completely. As a courtesy, we are happy to file an insurance claim on your behalf once active treatment is initiated. Without this information we are unable to file your claim.

Patient Name: _____ Patient's DOB: _____

Primary Insurance Co Name: _____ Phone # _____

Insurance Co. Address: _____City _____State _____ Zip _____

Subscriber's Full Name: _____Relationship to Patient:_____ DOB: _____

Subscriber's Address: _____City _____State_____ Zip_____

Social Security # _____Subscriber ID # _____Group #_____

Employer: _____ Work Phone # _____

Secondary Insurance Co Name: _____ Phone # _____

Insurance Co. Address: _____City _____State _____ Zip _____

Subscriber's Full Name: _____Relationship to Patient:_____ DOB: _____

Subscriber's Address: _____City _____State_____ Zip_____

Social Security # _____Subscriber ID # _____Group #_____

Employer: _____ Work Phone # _____

*******OFFICE USE *******

Ins. Co. _____ Date of Call _____ Name of Representative _____
Effective Date _____ Waiting Period _____ Deductible _____ Age Limit _____
Lifetime Benefit _____ Has Any Benefit Been Used? _____
Benefit Paid? Monthly – Quarterly – Annually – Other _____ Automatic? Yes or No
Benefit Coordination (if two): Standard or Non Duplication Does Birthday Rule Apply? Yes or No
Benefit Paid to: Subscriber or Provider

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Effective Date _____ Waiting Period _____ Deductible _____ Age Limit _____
Lifetime Benefit _____ Has Any Benefit Been Used? _____
Benefit Paid? Monthly – Quarterly – Annually – Other _____ Automatic? Yes or No
Benefit Coordination (if two): Standard or Non Duplication Does Birthday Rule Apply? Yes or No

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Banding Date: _____Procedure: _____Treatment Fee: _____Months of Tx:_____