WELCOME

To the office of Dr. John J. Brady

The benefits of a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset.

Please fill out these forms completely. The better we communicate, the better we can care for you.

1. ABOUT YOU

Today's Date: ____________________

Name: ______________________________________
Last First MI MR MRS MS DR

I prefer to be called: ______________ ❑ Male ❑ Female

Birth date: ______/______/______ Age: __________

Home Address: ______________________________

____
City State Zip

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Wk. # ________________ Hm # __________

Cell # ______________________________

E-mail: ______________________________

Employer: ______________________________

Occupation: ______________________________

How long there? ________ SS#: ______-_____-______

Where & when are the best times to reach you? __________

____

Who may we thank for telling you about our office?

____

Other family members seen by us: ______________

____

General Dentist: ______________________________

Last visit date: ____________________

2. SPOUSE INFORMATION

His/Her Name: ______________________________

Employer: ______________________________

Wk. # ______________________________

Person Responsible for Account

Name: ______________________________

Billing Address: ______________________________

____

Wk. # ______________ Hm. # ______________

Relationship: ____________ SS# ______-_____-______

Employer: ______________________________

How long there? ________________

3. PRIMARY ORTHODONTIC INSURANCE

Orthodontic Coverage? ❑Yes ❑ No

Insurance Co. Name: ______________________________

Insurance Co. Phone # ______________________________

Insured Name: ______________________________

4. MEDICAL HISTORY

Do you have a personal physician? ❑Yes ❑ No

Physicians Name: ______________________________

Date of last visit: ______________________________

4. MEDICAL HISTORY *continued*

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

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

____

Are you allergic to any of the following items?

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

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

____

5. 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 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

Do you have any speech problems? ______________

____

Do you generally breathe through your mouth?

❑ Yes ❑ No Awake? ❑ Yes ❑ No Asleep?

Do you have any missing or extra permanent teeth?

❑ Yes ❑ No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

______________________ __________
Signature Date

Thank you for filling out this form completely!

This office reserves the right to verify the credit status of the 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