vivid ORTHODONTICS

Brian M. Michel, D.D.S., M.S
Michael J. Maslowski, D.D.S., M.S.

PATIENT INFORMATION

Patient's Name _____ (First / Middle / Last)

Age _____ Birthdate _____ E-Mail Address _____

By What Name Does The Patient Prefer To Be Called? _____ Cell Phone _____

Home Address _____ (Number / Street / City / State / Zip Code) Home Phone _____

Social Security # _____ Sex _____ Marital Status _____

Patient's Occupation _____ Length of Employment

Employer / School _____ Work Phone _____

Hobbies / Musical Instruments _____

RESPONSIBLE PARTY INFORMATION (If Patient Is A Minor)

Father's Name ☐ Rev ☐ Dr ☐ Mr _____ (First / Last) Marital Status _____

Birthdate _____ Employer _____ Occupation _____ Length of Employment

Work Phone _____ Social Security # _____

Home Address _____ (Number / Street / City / State / Zip Code) Home Phone _____

E-Mail Address _____ Cell Phone _____

Mother's Name ☐ Rev ☐ Dr ☐ Ms ☐ Mrs _____ (First / Last) Marital Status _____

Birthdate _____ Employer _____ Occupation _____ Length of Employment

Work Phone _____ Social Security # _____

Home Address _____ (Number / Street / City / State / Zip Code) Home Phone _____

E-Mail Address _____ Cell Phone _____

PRIMARY DENTAL INSURANCE

If you have orthodontic insurance, please complete the following AND allow us to make a copy of your card.

Subscriber _____ Relationship to patient _____

D.O.B. _____ Social Security # _____

Employer _____ ID Number on Card _____

Insurance Company _____ Group Number _____

Address _____ Phone Number _____

SECONDARY DENTAL INSURANCE

Subscriber _____ Relationship to patient _____

D.O.B. _____ Social Security # _____

Employer _____ ID Number on Card _____

Insurance Company _____ Group Number _____

Address _____ Phone Number _____

MEDICAL INFORMATION

Patient's primary physician _____

Please check appropriate answer to the following questions. Your answers are confidential and for our records only.

	Yes	No
Are you taking any medication at this time? If yes, please list below:	☐	☐
Taking _____ for _____ Taking _____ for _____		
Taking _____ for _____ Taking _____ for _____		
Do you require premedication with antibiotics prior to dental procedures? _____	☐	☐
Do you have any allergies or drug sensitivities? If yes, please list _____	☐	☐
Are you allergic to latex - such as balloons or gloves? _____	☐	☐
Have you ever or do you currently smoke? _____	☐	☐

Have you ever had or been treated for any of the following conditions or diseases?
Check any boxes below that apply. If yes, please explain.

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma Or Hay Fever
- ☐ Blood Disease
- ☐ Bone Disorders
- ☐ Chemotherapy
- ☐ Convulsions
- ☐ Diabetes
- ☐ Diverticulitis / Colitis
- ☐ Dizziness Or Fainting
- ☐ Emotional Problems
- ☐ Excessive Bleeding
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Hearing Impaired
- ☐ Heart Problems
- ☐ Herpes
- ☐ Hepatitis - Specify Type _____
- ☐ HIV + Aids
- ☐ Kidney / Bladder Infection
- ☐ Malignancies (Cancer)
- ☐ Mononucleosis
- ☐ Thyroid Or Parathyroid Disorders
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Pregnant At This Time
- ☐ Do You Or Have You Ever Taken A Bisphosphonate Drug Such As: Pamidronate (Aredia), Zoledronate (Zometa), Alendronate (Fosamax)?
- ☐ Other _____

☐ Please Check Box If None Of The Above Apply.

Explanation Of "Yes" Responses: _____

_____

Yes ☐ No ☐ Any Other Condition Or Problem Which We Should Be Aware Of? _____

_____

DENTAL INFORMATION

Patient's dentist _____

Additional specialists seen _____ For what reason _____

Check any boxes below that apply.

- ☐ Face, Mouth or Teeth Injury
- ☐ Snoring
- ☐ Mouth Breathing
- ☐ Sore Throat
- ☐ Removal Of Tonsils
- ☐ Removal Of Adenoids
- ☐ Difficulty Chewing or Swallowing
- ☐ Speech Impairments
- ☐ Sucked Finger Or Thumb Until What Age _____
- ☐ Loss Of Permanent Teeth
- ☐ Growths Or Swelling In Mouth
- ☐ Food Frequently Lodged In Between Teeth
- ☐ Stiff Neck Muscles
- ☐ Clenching Of Teeth
- ☐ Grinding Of Teeth
- ☐ Clicking Or Popping Of The Jaw
- ☐ Difficulty Opening Mouth Wide
- ☐ Headaches - How Often _____

☐ Please Check Box If None Of The Above Apply.

Explanation Of "Yes" Responses: _____

_____

ORTHODONTIC INFORMATION

What is the primary concern? _____

_____

	Yes	No
Has the patient had previous orthodontic consultations or treatments? _____	☐	☐
If yes, when _____ by whom _____		
Other children in the family? If yes, what are their ages _____	☐	☐
Has anyone in the family had orthodontic treatment? _____	☐	☐
Names treated _____ by whom _____		

EMERGENCY INFORMATION

Name of nearest relative not living with you _____
Name Relationship

Address _____ Phone Number _____
Number Street City State Zip Code

How did you hear about our office?

☐ Friend _____ ☐ Website / Internet _____

☐ Dentist _____ ☐ Yellow Pages _____

☐ Other _____

Do you realize that appointments will infringe on school/work time? _____

The information given on this form is accurate to the best of my knowledge. I hereby give my consent to perform the necessary diagnostic tests (including x-rays) to adequately evaluate my/the patient's dental health. I also understand that where appropriate, credit bureau reports may be obtained. In addition, I understand that my electronic protected health information may be used by personnel in this office in connection with my treatment, payment of my account, or in contact with my insurance company or other health care providers as outlined in the office privacy practices.

_____ _____
Signature of patient, parent or guardian Date

The doctors of Vivid Orthodontics believe that certification, accreditations and teaching are important attributes to belonging to professional organizations. By signing below, I give consent to Vivid Orthodontics to use my records for these purposes. (It should be noted that all personal information would be held in confidence.)

_____ _____
Signature of patient, parent or guardian Date

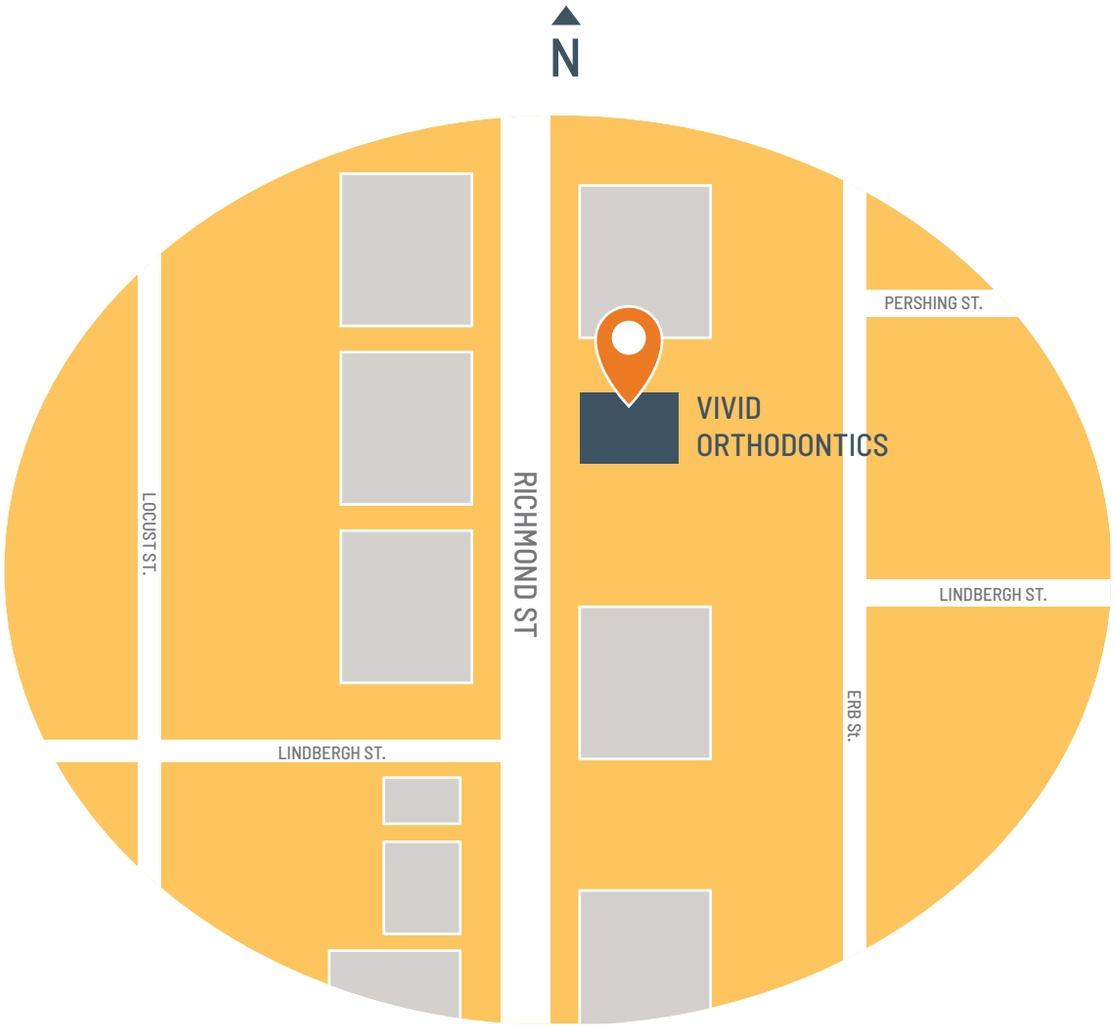
6 MONTH INTERVAL UPDATES

_____ _____
Initials Date

_____ _____
Initials Date

_____ _____
Initials Date

_____ _____
Initials Date



Vivid Orthodontics

2422 N. Richmond St. | Appleton, WI 54911

(920) 739-2400