B L A C K H A W K
O R T H O D O N T I C S

Welcome to our Office!

Date ____/____/____

Patient's Name _____ Date of Birth ___/___/_____

Address _____ City _____ Zip _____

Male / Female

Parent Name _____ Parent Cell/Work _____/_____

Parent Name_____ Parent Cell/Work _____/_____

Email address _____

School _____ Grade _____

Patient's Dentist _____ Date of Last Visit ____/____/____

Who Referred You to Our Office? _____

Dental History

What are your chief concerns? _____

How does the patient feel about braces? Enthused _____ Agreeable_____ Hesitant_____

Who first noticed orthodontic problems? Pt. ☐ M ☐ F ☐ Dentist ☐

Did you or do you do any of the follow?

Clench or Grind Teeth	Y / N
Suck Thumb	Y / N
Breathe with mouth open	Y / N
Brush Daily	Y / N
Injury to the mouth	Y / N

Do you or have you had?

Extra / Missing Teeth	Y / N
Teeth that have been Extracted	Y / N
Previous Ortho Consultation	Y / N
Previous Ortho Treatment	Y / N

Medical History

Patient's Physician _____ Date of last check-up ____/____/____

Heart Problems Y / N _____

Chronic Diseases Y / N _____

Medications presently taking Y / N _____

Do you pre-medicate before appt. Y / N _____

Allergies/ Drug Reactions Y / N _____

Operations/ Hospitalizations Y / N _____

Play instruments/ Sports Y / N _____

Anything else Dr. Anthony should know? Y / N _____

Member American Association of Orthodontists

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BLACKHAWK ORTHODONTICS

Insurance Information

Name of Insured_____ Relation to Pt._____

Address _____City _____Zip_____

Home Phone _____ Cell _____ Work_____

Date of Birth ____/____/____ Social Security #_____

Dental Insurance Company_____ Phone _____

Employer _____ Insured ID # _____ Group # _____

Emergency Information

Name of nearest relative not living with you _____

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____

I hereby authorize release of any information to other health care providers, insurance companies, and business associates including personal health information as well as administrative data which is not strictly dental or medical in nature. I additionally authorize payment directly to Richard Anthony, DDS MS for insurance benefits otherwise payable to me.

I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

I certify that the information on this form is complete and true to the best of my knowledge.

Signature (Parent's signature if minor)_____

Medical History Changes or Updates

Signature (Parent's signature if minor)_____Date ___/___/___

Signature (Parent's signature if minor)_____Date ___/___/___

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