Steele Creek | Plaza Midwood
(704) 269-8495
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dualimageortho.com

1. Patient Information

First Name: ____ Middle Initials: ____ Last Name: ____

Date of Birth: ____

Gender: ○ Female ○ Male ○ Nonbinary

Marital Status: ○ Single ○ Married

Street Address: ____ Apt./Unit #: ____ City: ____ State: ____ Zip Code: ____

Mobile Phone: ____ Home Phone: ____ Work Phone: ____

Email: ____

Preferred contact method: ○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email ○ Text

2. Responsible Party Information (if different from previous listing):

First Name: ____ Middle Initials: ____ Last Name: ____

Date of Birth: ____

Gender: ○ Female ○ Male ○ Other

Marital Status: ○ Single ○ Married

Street Address: ____ Apt./Unit #: ____ City: ____ State: ____ Zip Code: ____

Mobile Phone: ____ Home Phone: ____ Work Phone: ____

Email: ____

Preferred contact method: ○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email ○ Text

3. How did you learn about our practice or whom may we thank for referring you?

Referral Source

☐ Google ☐ Dentist ☐ Social Media ☐ Sign or Billboard ☐ Insurance Provider List ☐ Friend or Family

Friend or family (enter name) ____ Other Website ____ Other ____

Dental Health Professional ____

4. What is your primary concern(s)?

____

5. Have you previously had orthodontic treatment?

○ Yes ○ No

6. General Dentist Information:

Dentist Name: ______

Dental visit in last 6 months?: ( ) Yes ( ) No

Any scheduled treatments? ______

7. Do you have Orthodontic Insurance?

( ) Yes ( ) No

8. Primary Insurance

Primary Insurance Company ______ Member ID / Policy # ______ Group Number ______

Patient Relationship to Insured ( ) Self ( ) Spouse ( ) Child ( ) Other

Insured Name ______ Insured Phone # ______ Insured Date of Birth ______

Insured Street Address ______ Insured City ______ Insured State ______ Zip Code ______

9. Primary Insurance Card: Please take a photo of the back and front of your insurance card. Should treatment be recommended, providing your insurance card will allow us to share the portion of your orthodontic treatment fee covered by your plan.

10. Secondary Dental Insurance

Secondary Insurance Company ______ Member ID / Policy # ______ Group Number ______

Patient Relationship to Insured ( ) Self ( ) Spouse ( ) Child ( ) Other

Insured Name ______ Insured Phone # ______ Insured Date of Birth ______

Insured Street Address ______ Insured City ______ Insured State ______ Zip Code ______

11. Secondary Insurance Card: Please take a photo of the back and front of your insurance card. Should treatment be recommended, providing your insurance card will allow us to share the portion of your orthodontic treatment fee covered by your plan.

12. Check if you have or have had any of the following:

- [ ] Anemia
- [ ] Asthma/COPD
- [ ] Bleeding abnormally
- [ ] Cancer Treatment
- [ ] Diabetes
- [ ] Epilepsy
- [ ] Fainting
- [ ] GERD/Acid Reflux
- [ ] Headaches/Migraines
- [ ] Heart problems
- [ ] Hepatitis
- [ ] High blood pressure
- [ ] HIV AIDS
- [ ] Osteoporosis
- [ ] Pacemaker
- [ ] Rheumatic fever
- [ ] Stroke
- [ ] Tobacco use
- [ ] None of the above

Other/Details: ______

13. Indicate any history of (check all that apply); If checked "Yes", please explain.

- [ ] Thumb/finger sucking
- [ ] Tongue and/or swallowing problems
- [ ] Speech problems
- [ ] Loose teeth or broken fillings
- [ ] Grinding and/or clenching of teeth
- [ ] Tonsils and adenoids removed
- [ ] Crowns/Bridges
- [ ] Root canals
- [ ] Mouth breathing
- [ ] Snoring
- [ ] History of wearing a mouthguard at night
- [ ] History of Periodontal disease
- [ ] History of Periodontal treatment
- [ ] Mouth sores
- [ ] Injury to face or teeth
- [ ] Jaw Pain
- [ ] Clicking or popping jaw
- [ ] Difficulty opening or closing jaw
- [ ] Sensitivity when biting
- [ ] Cold, hot, or sweets sensitivity
- [ ] Food collection between certain teeth
- [ ] None of the above

Other/Details: ______

14. Please list any allergies you may have:

	Allergy
1	

15. List medications you are currently taking and the correlating diagnosis:

	Medication	Diagnosis
1		

16. Have you had any serious illnesses or operations? If yes, please describe.

____

17. What treatment option(s) interest you?

- ☐ Invisalign
- ☐ Clear/Metal Braces
- ☐ Retainers

Other:

____

18. If treatment is recommended, how soon would you like to get started?

- ☐ ASAP
- ☐ Within the week
- ☐ Within the month

Other:

____

19. What payment option(s) would you like to review?

- ☐ No-Interest Monthly Payment
- ☐ Payment in Full w/Special Courtesy
- ☐ HSA/FSA

Other:

____

20. Is there anything else you would like us to know before your visit?:

____

To the best of my knowledge, the above questions have been accurately answered. I am aware it is my responsibility to inform this office of any changes to my medical status. I permit to perform necessary orthodontic records, and I am aware you may use these records for in-office education.

______________________________ Signature

______________________________ Date