Windermere | Orlando
407-258-3262 | 407-995-6029
myfamilyortho.com

MyFamily Orthodontics®
BY DR. LAURIS JOHNSON

1. Patient Information:

First Name: _____ Middle Initials: _____ Last Name: _____

Date of Birth: _____ Gender: ○ Female ○ Male

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 ○ None

2. Primary Responsible Party Information:

First Name: _____ Middle Initials: _____ Last Name: _____

Date of Birth: _____ Gender: ○ Female ○ Male 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. Secondary Responsible Party Information (optional):

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

4. 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 (enter name) | Other Website | Other

5. What is your primary concern(s)?

6. Has your child had previous orthodontic treatment?

○ Yes ○ No

7. General Dentist Information:

Dentist Name: | Dental visit in last 6 months?: ○ Yes ○ No | Any scheduled treatments?

8. Do you have Orthodontic Insurance?

○ Yes ○ No

9. 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

10. 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.

11. 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

12. 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.

13. Check if your child has or has 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

Other/Details:

14. 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

Other/Details:

_____

15. Has patient reached puberty?

- ○ Yes
- ○ No

16. Please list any allergies:

	Allergy
1	

17. List current medications and the correlating diagnosis:

	Medication	Diagnosis
1		

18. Any serious illnesses or operations? If yes, please describe.

_____

19. What treatment option(s) interest you?

- ☐ Clear Aligners
- ☐ Clear/Metal Braces
- ☐ Retainers

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

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

Other:

_____

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

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

22. 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