MANFRED ORTHODONTICS
LAUREN N MANFRED, DDS, MS

Welcome to Manfred Orthodontics

The benefits of a happy, healthy smile are immeasurable! Please fill out this form completely. The better we communicate, the better we can care for you.

About You

Today's Date: _____

Name: _____

I prefer to be called: _____

__ Male __ Female

Birth Date: __/___/___ SS#: _____

Home Address: _____

_____

__ Single __ Married ___ Divorced

Home #:_____

Cell #: _____

Email: _____

Employer: _____

Occupation: _____

Whom may we thank for referring you?_____

Other family members seen by us:

_____

General Dentist: _____

Last Visit Date: _____

Spouse Information

His/Her Name:_____

Employer: _____

BirthDate: ___/___/___

Spouse Contact Number: _____

Emergency Contact

His/Her Name: _____

Relation: _____

Contact Phone: _____

Primary Orthodontic Insurance

Orthodontic Coverage: __Yes __No __ Don't Know

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Ph Number: _____

Group #: _____

Insured's Name: _____

Relationship to Parent: _____

Insured's Birth Date: _____/_____/_____

Insured's ID or SS#: _____

Insured's Employer: _____

Secondary Orthodontic Insurance

Orthodontic Coverage: __Yes __No __ Don't Know

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Ph Number: _____

Group #: _____

Insured's Name: _____

Relationship to Parent: _____

Insured's Birth Date: _____/_____/_____

Insured's ID or SS#: _____

Insured's Employer: _____

What are the Main Concerns that you would like Orthodontics to Address?

_____

_____

_____

_____

Medical History

Do you have a personal Physician? ___ Y ____N

Physician's Name: _____

Phone #: _____ Date of Last visit: _____

Are you taking any prescription drugs?: ____ Y ____N

Please list:

_____

_____

Are you pregnant?: _____Y _____N

Are you nursing?: _____Y _____N

Do you have any known allergies?: _____Y _____N

Please list:

_____

_____

Have you ever had any of the following diseases or medical problems?

Y N Anemia/Radiation Treatment	Y N Heart Surgery/Pacemaker
Y N Artificial Bones/Joints	Y N Hemophilia/Abnormal Bleeding
Y N Artificial Valves	Y N Hepatitis
Y N Asthma/Arthritis	Y N High/Low Blood Pressure
Y N Blood Transfusion	Y N HIV/AIDS
Y N Cancer/Chemotherapy	Y N Hospitalizations
Y N Congenital Heart Defect	Y N Kidney Problems
Y N Diabetes/Tuberculosis	Y N Mitral Valve Prolapse
Y N Difficult Breathing	Y N Psychiatric Problems
Y N Drug/Alcohol Abuse	Y N Rheumatic/Scarlet Fever
Y N Emphysema/Glaucoma	Y N Severe/Frequent Headaches
Y N Epilepsy/Seizures	Y N Shingles
Y N Fever Blisters/Herpes	Y N Sinus Problems
Y N Heart Attack/Stroke	Y N Uclers/Colitis
Y N Heart Murmur	

Please list any serious medical conditions that you have ever had:

_____

_____

_____

Dental History

Have you ever had or been evaluated for orthodontic treatment?: ___Y ____N

Have you ever had a serious/difficult problem associated with any previous dental work?: ___Y ___N

Do you now or have you ever experienced pain in your jaw joint? (TMD): ____ Y _____N

Have you ever had an injury to your mouth/teeth/face?: ____Y ____N

Do you have any speech problems?: ____Y _____N

Do you clench or grind your teeth?: ____Y _____N

Do you have any missing or extra permanent teeth that you know of?: ____ Y _____N

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information 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 that I may need during diagnosis and treatment with my informed consent.

Signed: _____

Date: _____

OFFICE USE ONLY:

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Doctor Signature: _____

Date: _____

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