Elizabeth W. Pawlak, DMD
Specialist in Orthodontics

160 Demaree Dr.
Madison, IN 47250
(812) 273-8744

We would like to welcome you to our office. Our goal is to make every visit pleasant and educational. The better we are able to communicate, the better care we can provide for you.

About You

Today's Date: ____

Name: ____

I prefer to be called: ____

Home Address: ____

____
City State Zip

Home #: ____________Work #: _____________Cell #: ____________

Where and when are the best times to reach you:

____

____

Other family members seen by our office (past & present):
____

Birthdate: _______/________/_______ Age: _________

Social Security # (*required*): ______________________________

General Dentist: ____

Date of Last Visit: ____

Whom may we thank for referring you?

____

Person Responsible for Account

Name: ______________________Relation: ____________________

Address: ____

____
City State Zip

Social Security # (*required*): ______________________________

Birthdate: _______/________/_______

Home #: ____________Work #: ____________Cell #: _____________

Primary Orthodontic Insurance

Orthodontic Coverage? ____Yes ____No

Insured's Name: ____________________Relation: ______________

Insured's Birthdate: _______/________/_______

Social Security # (*required*): ______________________________

Insured's Employer: ______________________________________

Employer Address: ______________________________________

Insurance Co. Name: ______________________________________

Insurance Co. Address: ____________________________________

Insurance Co. Phone #: ____________________________________

Group # (Plan, Local, or Policy #): ____________________________

Secondary Orthodontic Insurance

Orthodontic Coverage? ____Yes ____No

Insured's Name: ____________________Relation: ______________

Insured's Birthdate: _______/________/_______

Social Security # (*required*): ______________________________

Insured's Employer: ______________________________________

Employer Address: ______________________________________

Insurance Co. Name: ______________________________________

Insurance Co. Address: ____________________________________

Insurance Co. Phone #: ____________________________________

Group # (Plan, Local, or Policy #): ____________________________

In the event of an emergency, who should we contact?

Name: ______________________Relation: ___________________

Home #: ____________Work #: ____________Cell #: ____________

Continued

What are the main concerns that you would like orthodontics to address?

____

____

Have you ever been evaluated or had orthodontic treatment before?
____Yes ____No

Have there been any injuries to the face, mouth, teeth or chin?
____Yes ____No

Have your adenoids or tonsils been removed?
____Yes ____No

Have you ever been informed of any missing or extra permanent teeth?
____Yes ____No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)?
____Yes ____No

Your current dental health?
____Good ____Fair ____Poor

Have you ever had a serious/difficult problem associated with any previous dental work?
____Yes ____No

Please describe your physical health:
____Good ____Fair ____Poor

Do you use tobacco or tobacco products?
____Yes ____No

Are you currently under the care of a physician?
____Yes ____No

If yes, please explain: ____

____

Please list all drugs, including over-the-counter medications, that you are currently taking: ____

____

Please list all drug allergies: ____________________________________

____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status. I also authorize the orthodontic team to perform the necessary dental services that I may need

Have you ever had any of the following medical problems?

Y N Seasonal Allergies
Y N Allergies to plastic
Y N Allergies to Latex/Metals
Y N Diabetes
Y N Rheumatic Fever
Y N Heart Murmur
Y N Congenital Heart Defect
Y N Heart Attack/Stroke
Y N Heart Surgery/Pacemaker
Y N Mitral Valve Prolapse
Y N Artificial Valves
Y N High/Low Blood Pressure
Y N Blood Transfusion
Y N Anemia/Radiation Treatment
Y N Surgeries
Y N Hospitalization
Y N Asthma
Y N Hepatitis
Y N Tuberculosis
Y N Mono
Y N Arthritis
Y N Thyroid Disease
Y N Ulcers/Colitis
Y N Emphysema/Glaucoma

Y N Artificial Bones/Joints
Y N Bone Disorders
Y N Cerebral Palsy
Y N Hemophilia
Y N Abnormal Bleeding
Y N Convulsions/Epilepsy
Y N HIV +/AIDS
Y N Venereal Disease
Y N Drug/Alcohol Abuse
Y N Difficulty Breathing
Y N Sinus Problems
Y N Shingles
Y N Fever Blisters
Y N Headaches
Y N Cancer or Chemotherapy
Y N Kidney/Liver Problem
Y N Cleft Lip/Cleft Palate
Y N Handicaps or Disabilities
Y N Hearing Impairment
Y N Psychiatric Problems
Y N Endocrine Problems
Y N Nutritional Problems
Y N Fainting or Dizziness

Please discuss any other medical problems that you have:

____

____

____

Did or do you currently have any of the following habits?

Y N Thumb/Finger Sucking
Y N Lip Sucking/Biting
Y N Clenching/Grinding
Y N Mouth Breathing
Y N Speech Problems
Y N Nail Biting
Y N Tongue Thrust

Please give us an e-mail address for potential appointment confirmation in the future: ____

____
Signature of patient Date