Morse Stonecypher DDS MS INC
Certified Specialist in Orthodontics

# MEDICAL/DENTAL/INSURANCE INFORMATION
## *ADULT*

**PATIENT INFORMATION**

Last Name_____ First Name _____ Middle Name _____
Date of Birth M / D / YEAR Age _____ Male☐ Female☐
Mailing Address _____
City _____ Prov. _____ Postal Code_____
Home Phone # _____ Cell Phone # _____
Work #_____ E-mail Address _____
Employer _____
Immediate family members treated by Dr. Clawson _____
Family Doctor_____ Dentist _____

**Please √ Yes or No to the following questions:**

Under continuous care of a physician? Yes No If Yes, please explain:

_____

Prior evaluation for orthodontic treatment? Yes☐ No☐
History of difficulty or pain when opening mouth? Yes☐ No☐
Prior treatment for jaw joint problems (TMJ)? Yes☐ No☐
Frequent headaches? Yes☐ No☐
Missing or extra teeth? Yes☐ No☐
Injury to: Teeth? Yes☐ No☐ Mouth? Yes☐ No☐ Chin? Yes☐ No☐
Clenching or grinding teeth? Yes☐ No☐
Mouth breathing? Yes☐ No☐
Tongue thrusting? Yes☐ No☐
Are antibiotics required prior to dental procedures? Yes☐ No☐
Allergies to food or medications? Yes☐ No☐ if Yes, Please list:
Have you had a panorex X-ray in the last 12 months? Yes☐ No☐

_____

Allergy to metals? ie: nickel Yes☐ No☐
Allergy to latex (gloves or balloons)? Yes☐ No☐
Have you ever taken oral bisphosphonate medication? (Fosamax, Actonel, Didrocal)? Yes☐ No☐
Females only: are you pregnant? Yes☐ No☐

## HISTORY OF SERIOUS ILLNESSES SUCH AS: (PLEASE ✓ IF APPLICABLE)

- ☐ Abnormal blood pressure
- ☐ Anemia
- ☐ Arthritis
- ☐ Blood disorders
- ☐ Bone disorders
- ☐ Congenital heart defect
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ HIV
- ☐ Kidney disease
- ☐ Liver Disease
- ☐ Lung / breathing problems
- ☐ Mental / nervous disorder
- ☐ **None of the above**

Other illnesses, conditions or any birth defects, please specify:

_____

_____

I understand that the information I have provided is correct and complete to the best of my knowledge and that it will be held in confidence. I understand that it is my responsibility to inform Dr. Clawson of any change in my medical status.

_____ _____

Signature Date

## INSURANCE INFORMATION

Is there an insurance plan or plans that covers orthodontic treatment? Yes ☐ No ☐
If "Yes", please complete the following:

Primary Insurance Company (e.g. Manulife):_____
Policy Holder's Name_____
Policy Holder's Address_____
Policy Holder's Date of Birth_____ M / D / YEAR
Employer_____

Identification # on card:_____
(could be listed as ID#, certificate # or SIN #)
Group # on card:_____
(could be listed as group#, policy#, or plan#)

Secondary Insurance Company (e.g. Manulife):_____
Policy Holder's Name_____
Policy Holder's Address_____
Policy Holder's Date of Birth_____ M / D / YEAR
Employer_____

Identification # on card:_____
(could be listed as ID#, certificate # or SIN #)
Group # on card:_____
(could be listed as group#, policy#, or plan#)