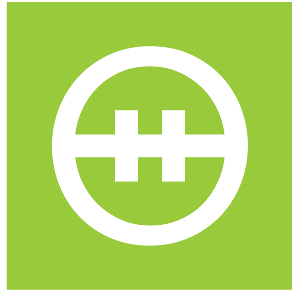

JOLLEY SMILES
ORTHODONTICS

Dr. Tyler H. Jolley D.M.D ▪ Dr. Zach Pitcher D.M.D, M.D.S.

Patient Information

Patient Information:

First & Last Name:________________________________ Preferred Name:________________
Mailing Address: ____
City:_________________________ State:______________________ Zip Code:_____________
Date of Birth: _______ /_______ /_______ Gender: ☐ M ☐ F
Best number to confirm your appointments: (_______) ________ - __________
Alternate Phone number: (_____) ______ - _________ SSN: _______________________
Are you a student? ☐ YES ☐ NO If so, what school do you attend? ________________
Email Address:____
Dentist: ____________________________________ Date of last visit: ________________
Physician: ____________________________________ Date of last visit: ______________
Are you related to any of our current patients?: ☐ YES ☐ NO
If so, who?:______________________________
Who may we thank for referring you? ____

Billing Party:

First & Last Name: ____________________________ Relationship to patient: ___________
Billing Address: ____
City:_________________________ State:______________________ Zip Code:_____________
Phone number: (_______) _______ - _________ SSN: _____________________________
Email: _________________________________ Spouse: _______________________________
Date of Birth:____ /_____ /______ Employer: _________________ Marital Status: __________

As a courtesy to our patients we will be happy to file insurance claims on your behalf. We can provide pre-authorizations if needed and are working to help you maximize your insurance benefits. To have claims processed in a timely manner we do need a copy of your dental insurance card and the following information filled out completely.

Insurance Information:

Do you have dental insurance? ☐ YES ☐ NO
Insurance Company Name: ______________________________
Policy ID Number: ______________________ Group Number: ______________________
Effective Date: ______________________________
Is it an employer plan? ☐ YES ☐ NO
Employer Name: ______________________________
Employer Address: ______________________________
City: ______________________ State: __________ Zip Code: __________
Employer phone number: (_______) ________ - __________

Subscriber First and Last Name: ______________________________
Relationship to patient: ______________ Date of Birth: ________ SSN: ______________
Address (if different from billing party): ______________________________
City: ______________________ State: __________ Zip Code: __________
Phone Number: (_______) ________ - __________

Check the box if you have, or if you have ever had, any of the following:

☐ Birth Defects or hereditary problems
☐ Bone fractures, any major accidents
☐ Rheumatoid or arthritic conditions
☐ Endocrine or thyroid problems
☐ Kidney Problems
☐ Tired Easily
☐ Chest Pain, shortness of breath or swelling ankles
☐ Cardiovascular problems (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)
☐ Frequent headaches, colds, sore throats
☐ Eye, ear, nose, or throat condition
☐ Hayfever, asthma, sinus trouble or hives
☐ Tonsil or adenoid conditions
☐ Osteoporosis
☐ Mental health disturbance or depression
☐ Vision, hearing, tasting, or speech difficulties
☐ Rapid weight loss, poor appetite
☐ History of eating disorder (anorexia, bulimia)
☐ Excessive bleeding or bruising tendency, anemia or bleeding disorder
☐ High or low blood pressure
☐ Diabetes
☐ Cancer, tumor, radiation treatment or chemotherapy
☐ Stomach ulcer or hyperacidity
☐ Skin disorder
☐ Polio, mononucleosis, tuberculosis, pneumonia
☐ Problems of the immune system
☐ AIDS or HIV positive
☐ Hepatitis, jaundice, or liver problems
☐ Fainting spells, seizures, epilepsy or neurological problems
☐ Substance abuse problem
☐ Chew or smoke tobacco

Allergies or reactions to any of the following:

☐ Metals (Jewelry, clothing snaps)
☐ Latex (Gloves, balloons)
☐ Vinyl
☐ Acrylic
☐ Other Substances (specify) ________
____
____
____

Women Only:

☐ Are you pregnant?
☐ Are you currently taking birth control?

Are you taking medication, dietary supplements, herbal medications or non-prescription medicine?

If so, please list: ______________________
____
____
____

Dental History:

Check the box if you have, or if you have ever had, any of the following:

- ☐ Permanent or "extra" (supernumerary) teeth removed
- ☐ Supernumerary (extra) or congenitally missing teeth
- ☐ Teeth sensitive to hot or cold; teeth throb or ache
- ☐ Jaw fractures, cysts or mouth infections
- ☐ "Dead teeth" or root canals treated
- ☐ Bleeding gums, bad taste or mouth odor
- ☐ Periodontal "gum problems"
- ☐ Food impaction between teeth
- ☐ "Gum Boils", frequent canker sores or cold sores
- ☐ Thumb, finger or sucking habit... Until what age______
- ☐ Abnormal swallowing habit (tongue thrusting)
- ☐ History of speech problems
- ☐ Mouth breathing habit, snoring or difficulty in breathing
- ☐ Tooth Grinding or Jaw Clenching
- ☐ Any pain, clicking, locking in jaw or ringing in the ears
- ☐ Difficulty in chewing or jaw opening
- ☐ Local anesthetics (Novocaine or Lidocaine)
- ☐ Been treated for "TMD" or "TMJ"
- ☐ Aware of any loose, broken or missing restorations (fillings)
- ☐ Any teeth irritating cheek, lip, tongue or palate
- ☐ Concerned about spaced, crooked or protruding teeth
- ☐ Aware or concerned about under or over developed jaw
- ☐ Relatives with similar tooth or jaw relationships
- ☐ Wisdom tooth problems
- ☐ Periodontal (gum) treatment
- ☐ Serious trouble associated with any previous dental treatment
- ☐ Been under another dentist's care
  Specialist: ______________________
  Other: ______________________
- ☐ Prior orthodontic examination or treatment

Would you object to wearing an orthodontic appliance (i.e. braces) should they be recommended by the doctor? YES NO

How often do you brush? ________________ Floss? ________________

What is your primary concern? Why are you here? ______________________________

____

____

____

____

I have read and understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will inform this practice.

Signed:____ Date Signed:________________
(Patient)

Signed:____ Date Signed:________________
(Parent or Guardian if under 18)