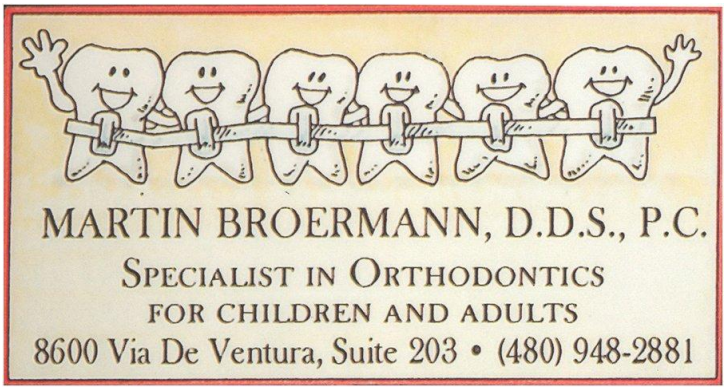

MARTIN BROERMANN, D.D.S., P.C.

SPECIALIST IN ORTHODONTICS
FOR CHILDREN AND ADULTS
8600 Via De Ventura, Suite 203 • (480) 948-2881

Our goal is to provide personalized orthodontic treatment in a caring environment.

We look forward to working with you to achieve an optimum result!

Tell us about You

Today's date___/___/___

Patient's Name_____

Nickname_____

Birth date ___/___/___ Age_____ Male Female

Home Phone (_____)_____

Home Address_____

_____

Cell # (_____)_____

Work # (_____)_____ext _____

Employer_____ Job Title_____

How long there? _____

SS#_____

General Dentist_____

Last Visit_____

Spouse Information

Name_____ _____

Employer_____ Job Title_____

Work#(_____)_____ext____ Birth date___/___/___

Cell # (_____)_____SS#_____

SS#_____

Person Responsible for Account

Name_____ Relation_____

Billing Address_____

_____

Home # (_____)_____Cell # (_____)_____

Primary Orthodontic Insurance

Orthodontic coverage Yes No If no orthodontic coverage skip this section

Insurance Co. name_____

Insurance Co Phone # (_____)_____Group #_____

Policy Owner's name_____

Relation to Patient_____

Policy Owner's Birthday___/___/_____ ID #_____

Policy Owner's Employer_____

Secondary Orthodontic Insurance

Orthodontic coverage Yes No

Insurance Co. name_____

Insurance Co Phone # (_____)_____Group # _____

Policy Owner's name_____

Relation to Patient_____

Policy Owner's Birthday___/___/_____ ID #_____

Policy Owner's Employer_____

Please fill out the health history on the next page

Medical History

Your current physical health is good fair poor

Are you currently under the care of a physician? Y N

Please explain_____

Are you taking any prescription/over the counter drugs? Y N

Please List _____

Have you ever taken Fosomax or any other bisphosphonate Y N

For Women: are you using a prescribed birth control? Y N

Are you pregnant? Y N Week #_____

Are you nursing Y N

Have you ever had any of the following diseases or medical conditions? Please circle if Yes:

Abnormal bleeding	Hemophilia
Anemia	Hepatitis
Artificial bones/joints/valves	High/Low Blood Pressure
Asthma/Arthritis	HIV/AIDS
Blood Transfusion	Hospitalized
Cancer/Chemotharapy	Kidney Problems
Congenital Heart Defect	Mitral Valve Prolapse
Diabetes	Psychiatric Problems
Difficulty Breathing	Radiation Treatment
Drug/Alcohol Abuse	Rheumatic/Scarlet Fever
Emphysema	Severe/Frequent Headaches
Epsilepsy/Seizures/Fainting	Shingles
Fever Blisters/Herpes	Sickle Cell Disease/Traits
Glaucoma	Sinus Problems
Heart Attack/Stroke	Tuberculosis
Heart Murmur	Ulcers/Colitis
Heart Surgery/Pacemaker	Venereal Disease

Please list any serious medical condition(s) you have ever had

_____

_____

Please circle those you are allergic to

Aspirin	Dental Anesthetics	Penicillin
Metals	Erythromycin	Tetracycline
Codiene	Latex	Other

Please list other drugs or materials you are allergic to_____

_____

What major concerns do you want to address with orthodontic treatment?

_____

_____

I am interested in Metal Braces Clear Braces Invisalign Other

Have you ever had or been evaluated for orthodontic treatment? Y N

Have you ever had any problems with previous dental work? Y N

Do you like your smile? Y N _____

_____

Have you ever had any injury to your Face Mouth Chin Teeth

Please comment

_____

Have you ever had any problems with your jaw joints/TMJ/TMD? Y N

Please comment_____

Overall your present dental health is Good Fair Poor

Do you have any missing teeth? Y N

Do you have any extra teeth? Y N

Do your gums ever bleed? Y N

Do you smoke? Y N

Do you use tobacco? Y N

Do clench or grind your teeth? Y N

Have you ever been told you are a mouth breather? Y N

Have you ever been told you have tongue thrust? Y N

The information I have given today is correct to the best of my knowledge. I understand this information will be kept strictly confidential . I also understand that it is my responsibility to inform this office of any change in my medical/health history. I also authorize the dental staff to perform any necessary dental services during diagnosis and treatment with my informed consent.

_____

signature date