freeman orthodontics

Patient Info

Name _____
First *Last*

☐M ☐F Preferred Pronoun: ☐He ☐She ☐They

Preferred Name_____ Age____ DOB ___/___/___

Address _____

City _____ Zip _____

School _____

Any Hobbies?_____

Who referred you to our office? _____

Primary Contact

☐Self ☐Mother ☐Father ☐Other _____

Name _____ Phone _____-_____-_____

Email _____

EMERGENCY CONTACT

☐Self ☐Mother ☐Father ☐Other _____

Name _____ Phone _____-_____-_____

Health Info

Main Concern?_____

Dentist _____ Recent Cleaning? ☐Yes ☐No

Have you ever had...	Yes	No	
	☐	☐	Thumb sucking
	☐	☐	Pain on side of face
	☐	☐	Grinding teeth
	☐	☐	Sensitive teeth
	☐	☐	Traumatic injury to mouth
	☐	☐	Antibiotics required before dental treatment
	☐	☐	Latex allergy
	☐	☐	Metal allergy
	☐	☐	Dental anesthetics allergy
	☐	☐	Asthma
	☐	☐	Heart Condition
	☐	☐	Active Hepatitis
	☐	☐	Diabetes
	☐	☐	Fainting
	☐	☐	Bisphosphonates
	☐	☐	Are you pregnant?

All other conditions: ☐ None _____

_____

All Medications: ☐ None _____

Signature

I won't hold Freeman Orthodontics liable for any action or non-action due to omissions in this form. I consent to exam and x-rays.

X _____ Date _____

What's Important to You? (Check Only Two)

☐ Invisible ☐ Convenience

☐ Works Fast ☐ Cost Efficient

Primary Dental Insurance

Subscriber's Name _____

Insurance Name _____

Employer _____ DOB ____/____/____

ID / SSN#_____

Secondary Dental Insurance

Subscriber's Name _____

Insurance Name _____

Employer _____ DOB ____/____/____

ID / SSN#_____

Dr. Freeman's Notes

NOTES:_____

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U Brkt Pos:	VIP	VIP+	VIP++	
L Brkt Pos:	VIP	VIP+	VIP++	
Upper Brkt:	Standard	Flipped	Flocked	
Lower Brkt:	Standard	Flipped		
Bite Stops:	U4s	U6,7	U1s	L1s

Els: _____

Tongue Tamers: L2-2

Squeeze Exercises: 6x60