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 ☐

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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 ☐

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

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

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

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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#)

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