Account and Insurance Information

RYCKMAN ORTHODONTICS

MICHAEL RYCKMAN,DMD,MSD

We would like to welcome you to our office. Our goal is to make every patient's visit pleasant and educational. We strive to teach good oral care that will enable you to have a beautiful smile that lasts a lifetime.

ABOUT YOU

Today's Date_____/_____/_____ ☐ Male ☐ Female

Name:_____
Last First MI

Preferred Name:_____

Date of Birth:_____Age:_____

Home Address:_____

_____
City State Zip

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Home #:_____Cell #:_____

Work #:_____Ext:_____

Email:_____

Employer:_____

Occupation:_____

Who may we thank for referring you?_____

Other family members seen by us:_____

PERSON RESPONSIBLE FOR ACCOUNT

Name:_____Relation:_____

Billing Address:_____

_____
City State Zip

Cell #:_____Employer:_____

Email:_____

SPOUSE INFORMATION

His/Her Name:_____

Cell #:_____

Email:_____

Employer:_____

I UNDERSTAND THAT THE INFORMATION THAT I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE, THAT IT WILL BE HELD IN THE STRICTEST CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THE OFFICE OF ANY CHANGES IN MY MEDICAL STATUS. I AUTHORIZE THE DENTAL STAFF TO PERFORM THE NECESSARY DENTAL SERVICES I MAY NEED.

_____
SIGNATURE DATE

IF YOU HAVE DENTAL INSURANCE WITH ORTHODONTIC COVERAGE, PLEASE COMPLETE THE FOLLOWING

PRIMARY DENTAL INSURANCE

Policy Holder's Name:_____

Relationship to Patient:_____

Address:_____

_____
City State Zip

Phone #:_____DOB:_____

SSN or Member ID:_____

Employer:_____

Employer's Address:_____

_____
City State Zip

Insurance Company Name:_____

Insurance Company Address:_____

_____
City State Zip

Group #:_____

Phone #:_____

SECONDARY DENTAL INSURANCE

Policy Holder's Name:_____

Relationship to Patient:_____

Address:_____

_____
City State Zip

Phone #:_____DOB:_____

SSN or Member ID:_____

Employer:_____

Employer's Address:_____

_____
City State Zip

Insurance Company Name:_____

Insurance Company Address:_____

_____
City State Zip

Group #:_____

Phone #:_____

I HAVE REVIEWED THE FOLLOWING PLAN(S). I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF TREATMENT.

_____
SIGNATURE DATE

MEDICAL AND DENTAL HISTORY

RYCKMAN ORTHODONTICS

MICHAEL RYCKMAN,DMD,MSD

MEDICAL HISTORY

Local Emergency Contact Person

Name:_____Relation:_____

Cell #:_____Wk #:_____

Do you have a personal physician: ☐ Yes ☐ No

Physician's Name:_____

Phone #:_____

Your current physical health is:

☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician?

☐ Yes ☐ No

If yes please explain:_____

Are you taking any prescription/over the counter drugs:

☐ Yes ☐ No

Please list each one:_____

_____

Please list any known medications/items that you are allergic to:

_____

_____

For women:

Are you pregnant? ☐ Yes ☐ No Week #:_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS:

☐ Yes	☐ No	Artificial Bones/Joints
☐ Yes	☐ No	Artificial Valves
☐ Yes	☐ No	Asthma
☐ Yes	☐ No	Cancer
☐ Yes	☐ No	Congenital Heart Defect
☐ Yes	☐ No	Convulsions/ Epilepsy
☐ Yes	☐ No	Diabetes
☐ Yes	☐ No	Handicaps/Disabilities
☐ Yes	☐ No	Hearing Impairment
☐ Yes	☐ No	Heart Murmur
☐ Yes	☐ No	Hemophilia
☐ Yes	☐ No	Hepatitis
☐ Yes	☐ No	HIV+/AIDS
☐ Yes	☐ No	Kidney/ Liver Problems
☐ Yes	☐ No	Rheumatic/ Scarlet Fever
☐ Yes	☐ No	Tuberculosis (TB)

Please elaborate as necessary for any 'Yes' answers:

_____

_____

DENTAL HISTORY

General Dentist:_____

Office name:_____

Office address:_____

_____

City State Zip

Office phone #:_____

Last seen:_____

X-rays Taken? ☐ Yes ☐ No

Any treatment rendered?_____

Next Appointment:_____

WHAT ARE THE MAIN CONCERNS THAT YOU WOULD LIKE ORTHODONTICS TO ACCOMPLISH?

_____

_____

_____

Have you ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No

Have you ever had a serious/difficult problem associated with previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain/ discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Your current dental health is:

☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Do your gums bleed? ☐ Yes ☐ No

Have you ever smoked/chewed tobacco? ☐ Yes ☐ No

Have you ever had an injury to your:

(Please circle all that apply) Mouth Teeth Chin

Do you have speech problems? ☐ Yes ☐ No

If yes, please describe:_____

_____

Do you generally breathe through your mouth?

Awake? ☐ Yes ☐ No Asleep? ☐ Yes ☐ No

Do you have any missing or extra permanent teeth?

☐ Yes ☐ No

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