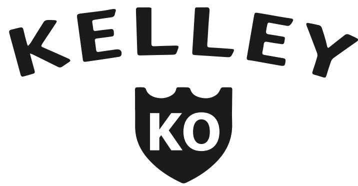

John M. Kelley, Jr., D.D.S., M.S.
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(817) 338-0771

WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health.
Please fill out these forms completely. The better we communicate, the better we can care for you.

1 General Information

Today's date: ______________________________

Name: ______________________________
Last First Mr. Mrs. Ms. Dr.

I prefer to be called: ____________________ □ Male □ Female

Birthdate: ___ / ___ / ___ Age: ______________

Home Address: ______________________________
Apt./Condo#

____
City State Zip

□ Single □ Married □ Divorced □ Widowed □ Separated

Home #: ______________ Cell #: ______________

Work #: ______________ Ext. #: ______________

Employer: ______________________________

Occupation: ______________________________

Who may we **Thank** for referring you? ______________

Other family members seen by us: ______________

____

____

2 Spouse Information

Name: ______________________________

Employer: ______________________________

Cell #: ______________________________

3 Emergency Information

Name of nearest relative not living with you:

Name: ______________ Relation: ______________

Cell #: ______________ Home #: ______________

4 Person Responsible for Account

Name: ______________ Relation: ______________

Billing Address : ______________________________

____
City State Zip

Cell #: ______________Work #: ______________

Employer: ______________ Occupation: ______________

Date of birth: ___ / ___ / ___

5 Primary Dental Insurance

Insurance Co. Name: ______________________________

Insurance Co. Address: ______________________________

____

Insurance Co. Phone #: ______________________________

Group #: ______________ ID #: ______________

Insured's Name: ______________ Relation: ______________

Insured's Birthdate: ___ / ___ / ___ S.S #:______________

Insured's Employer: ______________________________

I certify that I am covered by insurance with ______________
______________ , and assign directly to Kelley Orthodontics all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges not paid by insurance.** I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

______________________________ ______________

SIGNATURE DATE

Our office is HIPPA compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

6 Medical History

Physician's Name: ____

Phone #: __________________________Date of last visit: ______________

Your current physical health is: □ Good □ Fair □ Poor

Are you currently under the care of a physician? □ No □Yes

Please explain: ____

Are you currently taking any prescription/over-the-counter drugs?

□ No □ Yes

Have you ever taken a bisphosphonate drug?

Please list each one: ____

For women:

Are you pregnant? □ No □ Yes Week # ___________

Have you had any of the following diseases or medical problems?

Y	N	Heart Attack/Stroke	Y	N	Psychiatric Problems
Y	N	Cancer/Chemotherapy	Y	N	Epilepsy/Seizures/Fainting Spells
Y	N	Heart Murmur	Y	N	Diabetes/Tubercolosis (TB)
Y	N	Rheumatic Fever	Y	N	Drug/Alcohol Abuse
Y	N	HIV + / AIDS	Y	N	Venereal Disease
Y	N	Heart Surgery/Pacemaker	Y	N	Hemophilia/Abnormal Bleeding
Y	N	Shingles	Y	N	Ulcers/Colitis
Y	N	Mitral Valve Prolapse	Y	N	Congenital Heart Defect
Y	N	Kidney Problems	Y	N	Anemia/Radiation Therapy
Y	N	Artificial Bones/Joints	Y	N	Asthma/Allergies
Y	N	Artificial Valves	Y	N	Difficulty Breathing
Y	N	Sinus Problems	Y	N	Hospitalized for Any Reason
Y	N	High/Low Blood Pressure	Y	N	Hepatitis
Y	N	Fever Blisters	Y	N	Blood Transfusion
Y	N	Severe/frequent Headaches	Y	N	Emphysema/Glaucoma
Y	N	Sleep Apnea	Y	N	Arthritis

Comments: ____
____
____

Are you allergic to any medication?
____

Are there any health issues we should be aware of?
____

7 Dental History

What concerns you most about your teeth/bite?

____

Dentist's Name: ____

Last Visit Date: ____

Have you had previous orthodontic treatment? If so, when?

____

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

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

Clicking or Popping? □ No □ Yes

Do you currently or have you ever used any tobacco product?

□ No □ Yes

Do you require any pre-medication (antibiotics) prior to dental work?

□ No □ Yes

Your current dental health is: □ Good □ Fair □ Poor

How many times a week do you floss? ________________________________

How many times a day do you brush? ________________________________

Do you use an electric toothbrush? ____________ Brand? _______________

Do you use a waterpik? ____

8

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in medical status.

Office Use Only

I verbally reviewed the medical/dental information above with the patient herein. TX Coord: _____________ Date: ______________

Comments: ____
____