Clay Spencer DDS, MS

Specialist in Orthodontics

707 Lamar Avenue, Suite L · Paris, Texas 75460

Patient Information

Date _____ Age _____ Gender ☐M ☐F

Last First Middle

Patient's Name

Street City State ZIP

Address

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ Birth date _____ Social Security #_____

Employer _____ Occupation _____ No. Years Employed _____

Have we treated other family members?

_____

What is your chief concern?

_____

Whom may we thank for referring you to our office?

_____

Who is your general dentist?

_____

Spouse Information

Last First Middle

Name

Street City State ZIP

Address

Street City State ZIP

Mailing Address

Employer _____ Occupation _____ No. Years Employed _____

Social Security #_____ Birth date _____Work Phone _____

Insurance Information

Last First Middle

Insured's Name Birth date

_____

Social Security #_____ Employer _____ Insurance Co. _____

Group No. _____ ID No. _____Ins. Co. Phone _____

Street City State ZIP

Insurance Co. Address

Do you have dual coverage? ☐Yes ☐No *If yes, please add secondary insurance information below.*

Last First Middle

Insured's Name Birth date _____

Social Security #_____ Employer _____ Insurance Co. _____

Group No. _____ ID No. _____Ins. Co. Phone _____

Street City State ZIP

Insurance Co. Address

Emergency Information

Name of nearest living relative not living with you _____

Relationship _____

Street City State ZIP

Address

Phone _____ Alternate Phone _____

Medical Information

Yes	No		Yes	No		Yes	No
☐	☐	Heart Disease					
☐	☐	Blood Disease					
☐	☐	Thyroid Disease					
☐	☐	Bone Disease					
☐	☐	Cancer					
☐	☐	Emotional or Nervous Problems					
☐	☐	Endocrine Problems					
☐	☐	Problems with Wound Healing					
☐	☐	Asthma					
☐	☐	Diabetes					
☐	☐	Epilepsy					
☐	☐	Heart Murmur					
☐	☐	Hemophilia					
☐	☐	Hepatitis					
☐	☐	HIV Positive					

☐ ☐ Mitral Valve Prolapse
☐ ☐ Artificial Joints or Heart Valves
☐ ☐ Mononucleosis
☐ ☐ Prolonged Bleeding
☐ ☐ Rheumatism or Arthritis
☐ ☐ Tuberculosis
☐ ☐ Are you under Medical Care
☐ ☐ Are you in Good Health
☐ ☐ Women: Are you Pregnant
☐ ☐ Do you smoke or use tobacco
☐ ☐ Are you Allergic to Anything
If yes, what: _____

_____

☐ ☐ Have you ever taken Bisphosphonates (*i.e. Fosomax, Boniva, Actonel, Bonefos, etc.*)?
If yes, what: _____

_____

☐ ☐ Are you aware of any other disease, condition, or problem not listed above that we should know about?
If yes, what:_____

_____

_____

List any medications: _____

_____

_____

Dental History

Yes No

☐ ☐ Have you seen a general dentist in the last year
☐ ☐ Has the mouth, face or teeth been injured by a fall or accident
☐ ☐ Have you been informed of missing or extra permanent teeth
☐ ☐ Are you aware of any "gum" or periodontal problems
☐ ☐ Have your tonsils or adenoids been removed
☐ ☐ Has a physician or dentist advised antibiotics before a dental exam
☐ ☐ Any clicking or popping of the jaw
☐ ☐ Any jaw discomfort or pain

Do you have or ever had any of the following habits:
Yes No
☐ ☐ Thumb sucking
☐ ☐ Fingernail biting
☐ ☐ Clenching or grinding teeth

☐ ☐ Tongue thrusting

☐ ☐ Speech problems

☐ ☐ Have you been examined by an orthodontist before?

If yes, when: _____

I certify that the information on this form is correct. I understand that it is my responsibility to report any changes.

Signature of Patient _____ Date _____

For Office Use Only

File Only No/Cov Acc/Ins